Plano Counseling Center

2419 Coit Road, Suite C
Plano, Texas 75075
972-897-1507
http://www.PlanoCounselingCenter.com

Welcome!

We look forward to providing you with a meaningful and professional counseling experience. Wherever you are in your journey, we can help you reach your personal goals.

Our dedicated and professional team of mental health providers work together to provide you a full service of Therapeutic Modalities that best serve your individual needs.

Our Center is committed to provide the highest quality of professional service in a caring, compassionate manner. We believe everyone has the potential to create the life they truly desire.

Our mission is to help you attain your ultimate level of health possible. Helping you to feel relaxed and comfortable with our listening ear and teaching you the necessary tools to help improve your quality of life.

We are here to help you...

Please take a few moments to complete the following forms and bring them with you to the first session.

Thank you.

Karen S. Tyndall, LPC-S and Staff
Director and Supervisor

Adult Intake Form

CONFIDENTIAL

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:_____ Date of Birth_____ Age_____ Sex_____

Present Address_____
Number *Street*

_____
City State Zip Code

Phone: _____ Email:_____

Ethnicity_____ Years of Education_____ Referred by: _____

Marital Status: Single_____ Married_____(# of Years _____) Divorced_____ Separated_____

Presently Living With: Parents _____ Spouse _____ Roommate_____ Alone _____ Other _____

Occupation_____ Total Hours/Week_____

Employed by_____ Phone_____

Religious Affiliation_____ Church_____

Are you a member? Yes_____ No Active__ Inactive_____

Emergency Contact Name_____ Phone_____

Relationship_____

FAMILY MEMBERS

Relationship	Name	Age	Grade in School Last Completed	Occupation if Out of School
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Describe your relationship with your family members:

Describe any physical problems you have that require medication or physical care: _____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult with your primary care physician? _____

Are you currently taking any prescription medications? Yes _____ No _____ If yes, please list by name and dosage:

_____

_____

Do you smoke?_____ Type_____ How much do you smoke daily?_____

How much alcohol do you drink daily? _____

Type of Alcohol: _____

Have you ever used recreational drugs? _____ When?_____

Which ones?_____

Have you ever experienced substance abuse? Explain:_____

_____

Type of treatment used: _____

_____

Previous Counseling/Therapy Yes_____ No_____ If yes, when?_____

With whom? Name _____Address:_____

What did you like or dislike about your past counseling experience? _____

_____

_____

_____

_____

Briefly describe the problem which prompted you to seek counseling now: _____

_____

_____

_____

_____

Have you notice when these problems seem to appear more or less in your life? Yes _____ No _____

If yes, please explain: _____

_____

_____

_____

In the past, has there been any specific resources that have helped you during challenging times? Yes ____No____

Please explain: _____

_____

_____

_____

Are there other people who play a major role with your problems? Yes _____ No _____

Please explain: _____

_____

_____

Is there anything else that may be important to the counseling session? Please explain:_____

_____

_____

_____

_____

Using the scale below, please choose a number that reflects where you are in regards to today's issues.

0	1	2	3	4	5	6	7	8	9	10
Not Discouraged				Moderately Discouraged						Totally Discouraged

Of the list below, check the ones that are causing problems for you:

_____ Anger

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Nervousness

_____ Anxiety

_____ Use of alcohol

_____ Financial problems

_____ Marital problems

_____ Physical problems

_____ Problems with social relationships

_____ Problems with children

_____ Problems with parents

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Health Issues

_____ Family Issues

_____ Use of alcohol

_____ Loss/Grief

_____ Use of other drugs

_____ Work

_____ Worry

_____ Other (specify) _____

Center of Counseling Services, 2419 Coit Road, Suite C, Plano, Texas 75075, 972-897-1507

Client Agreement

Date:_____

Please note that all service charges are expected **prior** to the start of session and are the responsibility of the client and/or responsible party. Credit Cards and cash are accepted.

All therapy sessions are 45 minutes. If appointments are not cancelled within 24 hours prior, a cancel/missed appointment fee is $75.00 will be charged. Additional services provided include testing, as well as communication with teachers/attorney/etc., and cost $250.00 per hour, plus travel expenses if required. Past-due balances are sent for collection, and must be paid along with any expenses incurred in collecting the debt such as collection fees, legal fees, court costs and any other associated expenses. A 2.5% monthly interest rate will apply.

All counseling sessions are considered privileged information and are strictly confidential. They will not be disclosed to anyone without your consent **except when required by law.**

____ By initialing, I confirm that **all legal parents/guardians are in agreement and give full authorization and consent** for the following minor to receive counseling. Please print the information below.

Client Name: _____ Date of Birth: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Name of Guardian/Parent/Responsible Party: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone:_____ 2nd Phone:_____

Emergency Contact:_____ Phone Number:_____

Relationship to Client: _____

I have read all the attached material and voluntarily request counseling services for my minor child at according to the terms provided. Parent/Guardian/Responsible Party:

_____

Signature (Parent/Guardian/Responsible Party) *Print Name* *Date*

_____

Mental Health Professional Signature *Print name* *Date*

INFORMED CONSENT

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discuses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to admitted prenatal exposure to controlled substances that are potentially harmful.

Minor/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, date/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meaning and ramifications.

_____

Client Signature *Date*

_____

Print Name

Plano Counseling Center

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card)
Card Number: _____
Expiration Date (mm/yy): (CVV Code):
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date