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

CHILD AND ADOLESCENT INTAKE FORM / CONFIDENTIAL

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. This and all communications with your therapist, will be kept confidential to the full extent of Texas law.

BACKGROUND INFORMATION Date_____

Child's Name_____ Date of Birth _____Age_____

Child's Address_____
City *State* *Zip* *Contact Phone*

Child lives with: Both biological parents_____ Mother_____ Father_____ Mother & Stepfather_____

Father & Stepmother_____ Other (specify): _____

If parents are divorced, describe custody arrangements: _____

_____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name_____Age_____Race_____

Employer_____Occupation_____Hrs/wk_____

Employer's Address_____

Can you be contacted at work by phone? Yes No Work Phone:_____ Ext._____

Religious Denomination_____Church_____
Member? Yes No Active? Yes No

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

_____

Are you currently receiving medical treatment? Yes No Physician: _____

Medication(s) currently using: _____

Previous Counseling/Therapy? Yes No If yes, when? _____

With whom and for how long? _____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name_____Age_____Race_____

Employer_____Occupation_____Hrs/wk_____

Employer's Address_____

Can you be contacted at work by phone? Yes No Work Phone:_____ Ext._____

Religious Denomination_____Church_____
Member? Yes No Active? Yes No

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

_____

Are you currently receiving medical treatment? Yes No Physician: _____

Medication(s) currently using: _____

Previous Counseling/Therapy? Yes No If yes, when? _____

With whom and for how long? _____

FAMILY MEMBERS

List all people now living in the household, then draw a line, and below it, list others who have lived there during the child's lifetime:

Name	Relationship To Child	Age	Highest School Grade Completed	Occupation

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.)

0	1	2	3	4	5	6	7	8	9	10
Low					Moderate				High	

1._____ Anger/Temper
2._____ Depression
3._____ Divorce/Separation of Parents
4._____ Adjustment to Parent's Remarriage
5._____ School Performance
6._____ Family Problems
7._____ Fearfulness
8._____ Physical Problems
9._____ Problems with Social Relationships
10._____ Problems Sleeping
11._____ Nightmares
12._____ Sexual Concerns
13._____ Religious/Spiritual Concerns
14._____ Talk of self harm/harming others
15._____ Unhappy Most of the Time
16._____ Use of Alcohol
17._____ Use of Drugs
18._____ Work
19._____ Worry
20._____ Low Self-esteem
21._____ Poor Appetite
22._____ Overeating
23._____ Bedwetting
24._____ Soiling
25._____ Cruelty to Animals
26._____ Fire Setting

Other problem(s):_____

_____

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes No

If yes, please list results of test: _____

_____

_____

Has child had counseling previously? If yes, please name of counselor and address: _____

_____

Reason for contact:_____

_____

MEDICAL HISTORY

Were there any complications surrounding the child's birth? Yes_____ No_____ If yes, describe:_____

_____

_____

List child's sicknesses, operations, and injuries. Indicate age when occurred, and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:_____

_____

_____

_____

List current medical problems:_____

_____

Is child currently taking any prescription drugs? Yes_____ No_____ If yes, please list:_____

_____

When did your child last have a physical examination?_____

Name of Physician:_____Address:_____

_____

How is child's vision?_____Hearing?_____

ACADEMIC/SCHOOL INFORMATION

Name of school_____Grade_____Teacher_____

_____

_____

Has child ever repeated a grade?_____If so, which one(s)?_____

How does your child get along at school?_____

_____

Describe difficulties in learning at school_____

_____

Have other family members had learning difficulties?_____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc._____

_____

_____

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)_____

_____

_____

Anything else you think would be important for the counselor to know:_____

_____

_____

_____

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 where a client discloses or implies a plan for suicide, the mental health professional is required by law 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 professionals are required by law to report any 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 client's records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are, by law, 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:	*Print Name*	*Date*

Parent/Guardian Signature	*Print Name*	*Date*

Mental Health Professional Signature	*Print Name*	*Date*

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