Information, Consent, and Policies

We are honored that you have selected Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a graduate with a Master of Arts in Clinical Mental Health Counseling from Sam Houston State University. I am licensed by the state of Texas as a Licensed Professional Counselor Associate and supervised by Pam Cosart, LPC-S (License #66526). My formal education has prepared me to counsel individuals, groups, couples, families, adolescents, and children. My expertise includes counseling children through play therapy, individuals (adolescents and adults), families, marriage, parenting issues, and group psychotherapy.

I hold an abiding belief that no matter how difficult a person's circumstances may be, it is possible to produce meaningful change. I view the therapeutic relationship as collaboration with my client on a unique journey towards self-enhancement, wellness, and goal attainment. I view most issues as a systemic issue and helping a client function well within their own family, work, and social system is a primary goal. For that reason, I prefer working on relationship issues with all parties involved. My theoretical basis takes into consideration the developmental stage of not only the individual but the family as well. In this effort, we explore the emotional and psychological demands of individuation, and interpersonal and adaptive coping skill development. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or longer. This is truly an individual quest. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention. My expectations of my clients are to keep scheduled appointments, be forthright about issues and goals, and take an active and engaging role in the process.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we can concentrate exclusively on your concerns. You are best served by experiencing me in my professional role.

If at any time you are dissatisfied with my services, please let me know. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more effective for you. I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is not possible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results.

Please be aware that I do not provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

We respectfully request that CELL PHONES be turned off during your sessions.

Office Policies

____ Initial:
Session fee: $150.00 (50-minute duration)
After hour's session fee: $200.00
Miscellaneous: Charges for other professional services are prorated based on $150.00 per hour, 15-minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of $225.00 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

All fees for services or co-pay amounts are due at the time of the appointment. For payment, please see the office staff prior to each appointment. Follow-up appointments will not be honored if your account is overdue. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

____ Initial:
Legal testimony: Please be advised that I **do not** provide consultation, evaluation, or legal expert testimony in child custody, child visitation, or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $800.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are **payable in advance**.

_____Initial
Medicare & Medicaid: All of our counselors/therapists at Woodlands Family Institute, P.C. have opted out of being a Medicare and Medicaid provider. **All clients on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" to receive services at our practice.** All services must be paid at the time of service, and neither WFI, its counselors/therapists, nor the client may file a claim to Medicare for reimbursement.

Are you on Medicare or Medicare Eligible? ☐ yes ☐ no
If yes, please notify your counselor/therapist **BEFORE** your first session so you can sign the Medicare Opt Out Private Contract. **This is required for all Medicare or Medicare Eligible clients.**

Medicaid: We are not accepting any Medicaid patients; we will only accept "Private Pay" patients. We will not file any claims to Medicaid for reimbursement of your medical services now or at any time in the future

____ Initial:

Office hours: Monday through Friday, 9:00am-7:00pm. Friday, the office staff is available 8:00am-3:00pm. Any hours beyond stated office hours (Mon-Fri.) are considered as "after hours" and will be charged accordingly. After hours' time is generally reserved for family time and self-care.

____ Initial:

Cancellations:

All cancellations are expected to be made with 24-hour's notice. If you cancel your scheduled appointment less than 24-hours, or if you are a "no show," you will be charged the **full rate of the session**. Please note that insurance companies do not reimburse for missed appointments. **Please call WFI at: 281-363-4220 for cancellations, as email is not monitored daily for cancellations.**

____ Initial:

Insurance: Your health insurance policy is a contract between you and your insurance company. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Some insurance companies reimburse clients for services and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. Please be aware that third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated. The office staff will provide you with insurance-ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

____ Initial:

Confidentiality: All information disclosed within sessions is confidential and may be revealed only in certain situations. At times I may legally and/or ethically be required to share information about you without your consent. Such situations are, but are not limited to the following:

- Information released to other professionals involved in your treatment.
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are determined to be in imminent danger of harming yourself or someone else unless protective measures are taken.
- If you disclose abuse or neglect of children, the elderly, or disabled person. In the instance of reasonable suspicion of child or elder abuse.
- If you disclose sexual misconduct by a therapist.
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies).

CLIENT INFORMATION

First name: _____ Last name: _____

Age: _____ Birth Day: _____ Month: _____ Year: _____

Home address with postal code: _____

Cell #: _____ Home #: _____

Email:_____

Preferred method of contact:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Consent for treatment for clients 18 & older: I give full consent for myself to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Name of client: _____ Signature: _____ Date:_____

Consent for treatment for clients 17 & younger:

I give full consent for my child to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. **For minors of parents who have an active custodial order/divorce decree in place: It is required by the Texas State Licensing board that a copy of the current custodial order/divorce decree be kept on file stating who has the authority for making mental health decisions for a minor. It will be necessary to provide this BEFORE your child's first session.**

Name of client: _____ Date of birth: _____

Name of parent/guardian:_____ Signature: _____ Date:_____

Name of parent/guardian:_____ Signature: _____ Date: _____

REQUIRED: We require that a credit card be kept on file for all sessions. If you wish to use a different payment method at the time of your appointment, please notify the front desk before your session begins. This card will also be used for all after hours appointments, telehealth appointments, missed appointments or late cancel appointments.

Cardholder's Name_____ Relationship_____

MC/VISA/DISC No._____ Exp. Date _____

Signature of Authorized User _____

Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria, and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).

- In criminal court proceedings.
- In legal or regulatory actions against a professional.
- In proceedings in which a claim is made about one's physical, emotional, or mental condition.
- When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations.
- Where otherwise legally required.

____ Initial:

Emergency services: It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, if an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of a cure in the practice of psychotherapy.

_____ _____

Signature **Date**

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers, and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services, and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

Referred to our office by _____

May we send a thank you to the person who referred you? ☐ Yes ☐ No

May we mention your name in that thank you? ☐ Yes ☐ No

Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer-generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

☐ Via text message on my cell phone (normal text message rates will apply)

☐ Via email message to the address listed above

☐ Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24-hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

_____ _____

Signature Date

{Please refer to pages 7-8 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____ _____

Client or Authorized Representative Signature Date

☐ Refuse to Sign ☐ Unable to Sign (specify reason) _____

_____ _____

Signature of Person Documenting Refusal or Inability to Sign Date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or
  legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Miranda Butler, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to the office manager or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

NOTICE TO CLIENTS: The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council, George H.W. Bush State Office Building, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701
Tel. (512) 305-7700 or 1-800-821-3205

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

Please complete the following questions about your child or adolescent prior to initial appointment.

DATE:_____

PATIENT NAME:_____ **BIRTH DATE:** _____**AGE:** _____

NICKNAME(S): usually used_____**SEX:** Male ☐ Female ☐

LEGAL GUARDIAN(S): _____

NAME OF PERSON(S) COMPLETING THE FORM: _____

RELATIONSHIP TO CHILD/ADOLESCENT: _____

1. **DESCRIPTION OF GOALS:**
   What behaviors and talk will you see and hear after things are better? Include what will be different for child and family. (For example: "We will be talking through problems without yelling at each other.")
   - **a.** _____
   - **b.** _____
   - **c.** _____

2. **FAMILY INFORMATION:**
   - **a.** Is the child **ADOPTED?** No☐ Yes☐ If yes, age of child when adopted: _____
     Is the child a **FOSTER CHILD?** No☐ Yes☐ If yes, list caseworker's information:
     Caseworker's Name: _____Phone: _____County: _____
   - **b. CHILD'S BIOLOGICAL PARENTS ARE NOW:**

     ☐ **Never Married** ☐ and together ☐ and separated, list date separated: _____
     ☐ **Married** How many years? _____
     ☐ **Separated** Date separated: _____
     ☐ **Divorced** Date divorced: _____
     Has either parent remarried? No ☐ Yes☐ If yes, when: _____
     ☐ **Deceased** List relationship and date deceased: _____
   - **c. CUSTODY AND VISITATION:**
     If divorced or separated, what is the custody arrangement and what is the visitation arrangement?
     How well do these arrangements work?

     Per ethical rules, copy of custody agreement required before seeing child.

     ☐ Not applicable

3. **CARETAKERS / OTHER IMPORTANT PERSONS:**
   List parents, siblings (biological, step, or adoptive), and other important persons who are not currently in the home:

NAME	AGE	CITY	RELATIONSHIP	FREQUENCY SEEN

Describe how the child gets along with the above persons:

4. SIBLINGS AND OTHER IMPORTANT FAMILY ?

Family Member/ Significant Other/ Other	Age	Living with patient?	Relationship to patient	Occupation
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Describe how the child gets along with the above persons:

5. SOCIAL AGENCIES: Please list any welfare, children's services connections, or social agencies, such as CPS involved with your family: None ☐

6. PATIENT HEALTH INFORMATION:

a. BIRTH WEIGHT: _____

Any problems with the pregnancy or delivery? No ☐ Yes ☐ If yes, please describe:

b. DEVELOPMENTAL MILESTONES: (List any problems below)

Infancy: Birth to two years. List any significant delays / problems such as feeding problems or slow to walk or talk: None ☐

Toddler / preschool: 2-5 years. List any developmental delays or difficulties such as trouble with toilet training, speech, or self-care: None ☐

School age: 8-12 years. Describe any delays or problems such as attention problems, refusal at attend school, or issues with puberty: Not applicable ☐ None ☐

Middle / High School: 13-18 years. Describe any delays / problems: Not applicable ☐ None ☐

c. VISION: Glasses / contacts? No ☐ Yes ☐ (describe) _____

d. PHYSICAL HANDICAPS or PHYSICAL CHALLENGES: None ☐ Yes ☐ If yes, please describe:

e. NUTRITION: Appetite is usually: Good ☐ Excessive ☐ Poor ☐ Variable ☐
Dental braces/appliances: None ☐ Yes ☐ (describe) _____

Do you have any concerns about the child's eating patterns or nutrition? No ☐ Yes ☐
If yes, please describe:

Is there a history of vomiting, binging, or excessive preoccupation with food? No ☐ Yes ☐
If yes, please describe:

f. MENSTRUATION: Not applicable ☐ Has menstruation begun? No ☐ Yes ☐
If yes, at what age did menstruation begin? _____

Has menstruation been: Regular ☐ Painful ☐

Do you think there are excessive signs of "PMS" (premenstrual syndrome)?: No ☐ Yes ☐
If yes, please describe:

g. SUBSTANCE USE: Not applicable ☐

Does child use, now or in the past, substances such as alcohol, marijuana or cocaine? No ☐ Yes ☐
If yes, please describe substances used, age of first use, and current usage patterns:

h. HEALTH AND MEDICATIONS:

Does child currently see a primary care doctor? No ☐ Yes ☐
Date of last visit? _____

Does the child have significant health concerns**?** No ☐ Yes ☐
If yes, please describe:

Does the child currently take medications, including for psychiatric reasons**?** No ☐ Yes ☐
If yes, please list medications with indications:

Please be aware that counselor encourages evaluation from medical doctor at onset of counseling to discuss behavioral and physical concerns.

7. VIOLENCE/ABUSE: Please describe any physical, verbal, emotional, or sexual abuse as the perpetrator, victim, or witness. Was the abuse reported to authorities? ☐ Not applicable.

_____

_____

8. TRAUMA: Please describe history and any concerns/issues of manmade, natural, or other trauma that may impact current treatment. ☐ Not applicable.

SEXUAL HISTORY: Please describe history and any concerns/issues that may impact current treatment such as: age of first sexual encounter, sexual orientation, pregnancies, birth control, traumatic experiences, extra-marital affairs, at-risk behaviors, and sexual difficulties. ☐ Not applicable.

_____

_____

9. SCHOOL INFORMATION: (*If in Day Care or Pre-school, please fill out as applicable)*

Name of School: _____ School Phone: _____

School Address: _____

Present Grade Level: _____ Special placement or classes? _____

Current Teacher: _____ Current Counselor: _____

Began school at what age? _____ Adjusted to school: Easily ☐ With difficulty ☐

Repeated a grade? No ☐ Yes ☐ If yes, list grade(s) repeated: _____

Best subjects: _____

Hardest subjects: _____

Most grades have been: A B C D F When, if ever, did work begin declining? _____

How does your child best learn? Reading ☐ Hearing ☐ Watching ☐ Hands-on ☐

Expulsions / Detentions / Suspensions? None ☐ Yes ☐ If yes, please describe:

Describe relationships with other students and teachers:

Additional comments about recent school behaviors?

10. SPIRITUAL BACKGROUND: Past and present religious affiliation, involvement in church, guiding spiritual principles.

OTHER FAMILY BACKGROUND INFORMATION

a. **RESIDENCES:** Number of times the family has moved since the child was born: _____
Date of most recent move: _____ Number of school changes: _____

b. **DISCIPLINE:** What forms of discipline do you use when correcting your child? Indicate the form(s) that you think work best for your child and family:
Time outs ☐ Grounding ☐ Loss of toy/privilege ☐ Spanking ☐ Praise ☐
Contracts ☐ Rewards ☐ Other (describe):

Who is the main disciplinarian in your home? _____

Is there anything you want to write about the rules in your child's home(s) and how discipline occurs?
No ☐ Yes ☐ If yes, please describe:

16. **LEISURE / HOBBIES / PLAY:** What does your child enjoy doing in her / her free time? In what social activities, extracurricular activities, lessons or sports is he / she involved?

What kind of activities does your **FAMILY** enjoy together?

17. **FINANCIAL:** How would you describe your current financial status? Has child ever had a job? (Describe any financial concerns you have currently):

18. **CHANGES:** Any other changes such as friends moving, changes in custody, parents' work hours, parents' health, etc.? None ☐ Yes ☐ If yes, please describe:

19. **MILITARY SERVICE:** Is anyone in the immediate family currently serving in the Armed Forces? No ☐ Yes ☐

Has past service in the Armed Forces affected this family's history and relationships?
No ☐ Yes ☐ If yes, please describe service branch, dates, stations, and deployments as applicable:

20. **FRIENDS / SOCIAL:** Do you have any concerns about your child's ability to choose and maintain friendships? No ☐ Yes ☐ If yes, please describe:

    Do you have a reason to believe child is being bullied by peers and/or bullying peers? No ☐ Yes ☐

21. **CULTURAL: Ethnicity / Race:** _____
    Are there any family cultural values or traditions the counselor should be aware of? (Foods, family organization, customs, etc.): No ☐ Yes ☐ If yes, please describe:

22. **PAST PSYCHIATRIC EXPERIENCES:** Please list names and dates of psychiatrists or hospitals, reason for visit, medications prescribed, and disposition: None ☐

23. **PAST COUNSELING EXPERIENCES:** Please list names and dates of therapists or clinics child has attended, topic of counseling, and disposition: None ☐

    TESTING: If psychological or educational testing has been done, summarize findings: None ☐

24. **STRENGTHS AND DIFFICULTIES:** What strengths or talents does your child have?

    What difficulties or limitations does your child have?

25. **OTHER INFORMATION:** Is there any other information about your child or family which you think would be helpful for the counselor to know? None ☐

SYMPTOM CHECKLIST INSTRUCTIONS: Please read each item carefully. If an item applies to the child or adolescent now or in the past, please check the item.

BEHAVIOR			Trouble concentrating
	Does things without thinking		Feels sad often / cries easily
	Refuses "no" for an answer		Does not seem to feel guilt
	Destroys property or belongings		Is extremely critical
	Steals		Seems afraid to make mistakes / easily embarrassed
	Lies often		Does not like to be touched
	Has been in trouble with police or probation		Resents even gentle criticism
	Sexual problems		Has an "I don't care" attitude
	Has run away from home		Has a "you cannot make me" attitude
	Has attempted or talked about suicide		Feels angry often
	Argues when told to do something		Feels bored often
	Delays doing as asked		Is afraid of "rough" play
	Cruel to animals		Has frequent nightmares
	Wants everything his/her own way		Other:
	Often tries to be the center of attention	**FAMILY**	
	Has temper tantrums or violent behavior		Sleeps in bed with parents
	Acts like a younger child		Avoids contact with family members
	Curses		Parents get along poorly with each other
	Sets fires		Clings to parents
	Nervous habits / anxiety / panic attacks		Other:
	Often pouts and sulks	**SOCIAL**	
	Prefers to be alone / avoids activities		Hangs around with a bad crowd
	Other:		Is too easily led by others
ACADEMIC			Chooses younger friends ____ older friends ____
	Is truant from school		Is often teased by others
	Does not complete assignments in classroom		Does not like being alone
	Does not do homework		Has few friends
	Feels unfairly treated by teachers or authorities		Tattles on other children
	Short attention span		Teases other children
	Often clowns around in class		Seems shy
	Refuses to go to school		Often boasts
	Is poorly organized in seat work		Often interrupts others
	Poor handwriting / sloppy work		Will note argue or fight back when most would
	Cannot sit still		Fights
	Makes grades below ability		Has EVER been sexually molested
	Has difficulty working in groups		Uses alcohol
	Rarely speaks up in the class		Uses drugs
	Rarely works without individual attention		Sells drugs
	Test anxiety		Smokes cigarettes
	Fears teacher(s)		Other:
	Trouble on the bus	**PHYSICAL**	
	Other:		Frequent physical complaints

THINKING / ATTITUDE			Trouble falling asleep ____ Sleeps too much ____
	Seems preoccupied with certain thoughts		Is tired much of the time_____
	Daydreams more than most		Is seriously overweight ____ underweight ____
	Says or does things over and over		Lost weight ____ Gained weight _____
	Hears or sees things that are not there		Hearing problems _____ Speech problems ____
	Seems unaware of what is happening		Vision problems
	Lacks self-confidence		Poor bladder control days____ nights____ wets bed ____