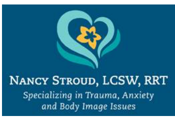

ADOLESCENT INTAKE FORM

Child's Name: ________________________ ***Age:*** ______ DOB: ______________

Sibling: ______________________________ Age: ______ DOB: ______________

Sibling: ______________________________ Age: ______ DOB: ______________

Sibling: ______________________________ Age: ______ DOB: ______________

Sibling: ______________________________ Age: ______ DOB: ______________

***Parent's Name*:** ______________________________ DOB: ____________

Address (City, State and Zip): ______________________________

Marital Status: ______________________ Male/Female: ______________

Phone: H (____) __________ W(_____) ______________ C(_____) ______________

OK to say Nancy Stroud Counseling? Yes__No__

Emergency contact (name and phone #) ______________________________

***Parent's Name*:** ______________________________ DOB: ______________

Address (City, State and Zip): ______________________________

Marital Status: ______________________ Male/Female: ______________

Phone: H( ) ______________ W( ) ______________ C( ) ______________

OK to say Nancy Stroud Counseling? Yes___ No___

Emergency contact (**name and phone #**) ______________________________

***Step Parent(s)/Guardian(s)*:** ______________________________ DOB: __________

Address: ______________________________

City, State and Zip: ______________ Marital Status: __________ Male/Female:

Phone: H( ) ______________ W( ) ______________ C ( ) ______________

OK to say Nancy Stroud Counseling? Yes__ No___
Emergency contact (**name and phone #**) ______________________________

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2717 Commercial Center Blvd, Suite E200, Katy, TX 77494
Office: 281.693.1455 Fax: 832.913.5101
www.nancystroud.com

History of Problem

Please describe what concerns you have regarding your child:

____

____

____

How long has the problem existed? ____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, and financial problems, in the last several years?

____

____

____

What attempts have been made to resolve the difficulties?________________________________

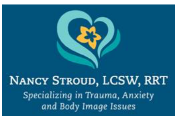
____

____

____

Please check the symptoms that the child is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Symptom	***Name/s***	***How Long?***	***Severity of symptom*** ***None, Mild, Moderate, Severe***
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive Thoughts			
Tension and Anxiety			
Panic Attacks			



History of Problem

Symptom	***Name/s***	***How Long?***	***Severity of symptom None, Mild, Moderate, Severe***
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Headaches			
Bed Wetting			
Phobias			
Other			

Parent Information

Are there any other agencies involved with the family (CPS, Child Welfare, Courts, etc)?

____

____

____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)____

____

____

Is ex-spouse (biological parent) aware that you are bring their children to Nancy Stroud Counseling?

Yes____No________

If not, please explain.____

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If adopted, does child know of adoption? Yes_________No _____________

What age was your child at the time of the adoption?____

Mother's Name:_________________________________Age:________Occupation:

Employment status: Employer's name and address:

____

Significant medical problems: ____

Serious illnesses, accidents, or surgeries in the past:_______________________________________

Current and past psychiatric treatment or counseling:____

Currently prescribed medications:____

Current alcohol/drug use (amount, how often, intoxication frequency):_________________________

____

History of alcohol/drug use?____

History of arrest?____

Primary Care Physician:____

Psychiatrist:____

Father's Name:_________________________________Age:________Occupation: _______________

Employment status: __________________________

Employer's name and address: ____

Significant medical problems:____

Serious illnesses, accidents, or surgeries in the past: _______________________________________

Current and past psychiatric treatment or counseling:____

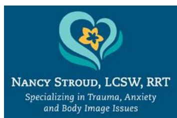
Currently prescribed medications:____

Current alcohol/drug use (amount, how often, intoxication frequency):_________________________

____

History of alcohol/drug use?____

History of arrest? ____



Primary Care Physician:______________________________

Psychiatrist:______________________________

Step-parent/Guardian:____________________Age: Occupation: __________

Employment status: Employer's name and address:

____

Significant medical problems:______________________________

Serious illnesses, accidents, or surgeries in the past:______________________________

Current and past psychiatric treatment or counseling:______________________________

Currently prescribed medications:______________________________

Current alcohol/drug use (amount, how often, intoxication frequency):______________________________

____

History of alcohol/drug use?______________________________

History of arrest?______________________________

Primary Care Physician:______________________________

Psychiatrist:______________________________

Child Information #1:

Name of Child:____________________Age:________Child lives with:__________

School:____________________Grade:________Teacher: __________

History of psychiatric treatment or counseling:______________________________

Current or past drug or alcohol use (indicate past or present amount, frequency)__________

____

Significant medical problems: ______________________________

Serious illnesses, accidents, or surgeries in the past: ______________________________

Medications currently prescribed: ______________________________

Pediatrician: ______________________________

Psychiatrist: ______________________________

Child Information #2:

Name of Child:________________________________Age:________Child lives with:____________________

School:____________________________________Grade:________Teacher: ____________________________

History of psychiatric treatment or counseling:____

Current or past drug or alcohol use (indicate past or present amount, frequency)___________________

____

Significant medical problems: ____

Serious illnesses, accidents, or surgeries in the past: ____

Medications currently prescribed: ____

Pediatrician: ____

Psychiatrist: ____

Child Information #3:

Name of Child:________________________________Age:________Child lives with:____________________

School:____________________________________Grade:________Teacher: ____________________________

History of psychiatric treatment or counseling:____

Current or past drug or alcohol use (indicate past or present amount, frequency)___________________

____

Significant medical problems: ____

Serious illnesses, accidents, or surgeries in the past: ____

Medications currently prescribed: ____

Pediatrician: ____

Psychiatrist: ____

How did you hear about Nancy Stroud Counseling?

____

____

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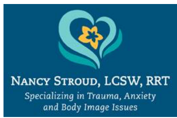

Adolescent Consent Form
and Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature ____ Date___________

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

- ☐ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.
- ☐ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.
- ☐ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature ____ Date____________

Parent Signature ____ Date____________

Therapist Signature ______________________________________ Date____________

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PAYMENT OF FEES

Paying for therapy is often a very sensitive topic. We can discuss your concerns about payment as needed. However, Texas law requires that all fee(s) are established and agreed to before we can begin. This section clarifies all fees, and defines your financial responsibilities.

The fees are as follows, payable each session and beginning at your first appointment:

50 Minutes individual therapy $130.00
50 Minutes couple counseling $140.00
4 Hours of Rapid Resolution therapy $350.00
Eating Disorders assessment $160.00

A $25.00 returned-check fee will be assessed.

1. Canceling or rescheduling appointments requires a (24) hour notice by telephone to avoid having to pay the entire fee for a missed session (No e-mails please.).

2. Telephone conversations between us, for any reason, in excess of (15) minutes per day may be billed proportional to your hourly fee.

Please initial here: ________

LEGAL / COURT **(all services)**

Any and all time spent by the provider in relation to any legal issue, including disability claims, notarizing, paperwork for claims, signing any type of document, is at a rate of $2,500 for the first 4-hour block or any part thereof. Every subsequent hour or part thereof, in the same day is at a rate of $325. Each additional day begins this fee cycle again: $2,500 for the first 4-hour block or any part thereof and every subsequent hour beyond the initial four, or part thereof, in the same day, at a rate of $325. This begins at the time provider leaves office and continues until the time they return. By signing this agreement, you agree to be solely and fully responsible for all payments due, should the clinician or any other member of this office, be required or requested to be involved in any legal proceeding; including but not limited to mediation, court/trial, depositions, phone conferences, meetings and consultative services. You are still responsible for these, under contractual law, even if the provider is summoned under a subpoena. This payment must be made, in full, on each day the provider spends such time in relation to any legal issue.

Please initial here: ________

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone about you.

2. Texas law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some exceptions to confidentiality include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:

   •you or your child presents a danger to self for others

   •a child or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering

   •a dependent adult or any person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect

   Note: the preceding is a sample, and not a complete list of exceptions to confidentiality.

Your initials here indicates agreement to the 'Confidentiality Limits & Exceptions': ________

MEDICAL, PSYCHIATRIC and PSYCHOLOGICAL EVALUATIONS

If medical, psychiatric and/or psychological evaluation seems warranted, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for evaluation(s) by other professionals is established and you do not follow these recommendations, your therapy may necessarily be suspended or terminated.

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you suspect you are in crisis.

2. As a standard business practice, each appointment ends 50 minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions since appointments begin on the hour.

3. Calls are retrieved from my voice mail at (281) 693-1455 several times during the day (M-F) at random intervals.

4. If necessary, my voice-mail will provide the name and telephone number of a colleague

who you can call for assistance when I am not available.

Your initials here indicates agreement to the 'Limits of Communications': ________

TREATMENT TERMINATION

1. Ideally, therapy ends when we agree your treatment goals have been achieved.

2. You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided.

3. Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases appropriate referral(s) will be offered.

4. Other situations that warrant terminate include: regularly becoming enraged or threatening during session; bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.

Your initials here indicates agreement to the 'Treatment Termination' conditions: ________

RISKS ASSOCIATED with PSYCHOTHERAPY

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

1. Disruptions in your daily life that can occur because of therapeutic changes

2. Emotional pain due to exploring personal issues and family history

3. Experiencing emotional pain within your current relationships

4. Although therapy begins with the hope that your life and relationship(s) improve, there is no guarantee that this will occur

Your initials here indicates agreement to the 'Risks Associated with Psychotherapy': ________

OFFICE ENVIRONMENT

Please be advised that if you leave your family members or unsupervised minors you will be responsible for their behavior and actions while you are on the premises.
This includes both the office and the building.

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

1. Your signature below will verify that you have read (or that I have read to you) the information in this authorization and you were given the opportunity to ask questions about

anything you did not understand up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods offered by Nancy Stroud, L.C.S.W. and in accordance with this 'Informed Consent.'

2. You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other 'third-party' payers.

3. You will also be releasing me of liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

FINANCIAL AND OFFICE POLICIES

OFFICE POLICIES:

Failure to keep your scheduled appointments with Nancy Stroud, L.C.S.W. hinders her ability to provide the best care to clients.

We ask that you show consideration by calling at least 24 hours prior to your appointment if you are unable to attend. Please call (281-693-1455) with your notification. This will allow the opportunity to offer that appointment to another client.
Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and my other clients. Missed appointments prevent other clients from coming in at the same time and affect the consistency of your own treatment program. As a result, 3 late cancellations or no shows will result in discontinuing therapy with Nancy Stroud, L.C.S.W.

Failure to give the 24 hour notice necessary prior to cancellation will result in a "No-Show Appointment Fee."

THE NO-SHOW APPOINTMENT FEE is $100.00.

Please provide valid credit card information in the space below. You will only be charged if you do not provide appropriate notice for your cancellation. You will be notified prior to being charged. You may dispute charges in writing to Nancy Stroud, L.C.S.W. Nancy Stroud, L.C.S.W. reserves the right to waive fee or honor charges at her discretion.

Client Signature
____

Current Date ______________________________

Client Signature
____

Current Date ______________________________

YOU ARE EXPECTED TO PAY AT TIME OF VISIT.

I understand my financial obligations to treatment received from Nancy Stroud, LCSW as stated above, and agree to pay for any and all services received. I understand that my credit card will be charged.

Name as it appears on the Credit Card:
____

Credit Card Type: Visa MC AMEX Other

Credit Card #: ____________________________________
Exp. Date: _________

I understand Nancy Stroud, L.C.S.W.'s appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify Nancy Stroud, L.C.S.W. appropriately if I have difficulty fulfilling my scheduled appointments.

Client Signature/Guardian Signature
____

Current Date _________________________________

Witness Signature
____

Current Date _________________________________