

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: _____

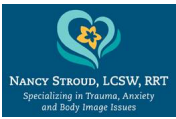
Address: _____

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 #) _____



History of Problem

Please describe what concerns you have regarding your child:

How long has the problem existed? _____

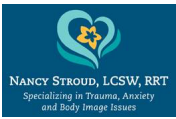
Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, and financial problems, in the last several years?

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

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

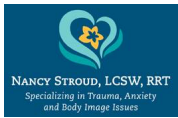
Parent Information

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. _____



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: _____

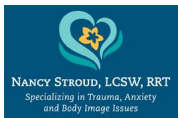
Current and past psychiatric treatment or counseling: _____

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) _____

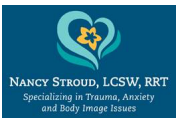
Significant medical problems: _____

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: _____

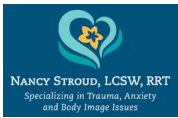
Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

How did you hear about Nancy Stroud Counseling?



Nancy Stroud L.C.S.W., RRT
Psychotherapist

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 _____

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:

60 Minutes individual therapy \$
60 Minutes couple counseling \$

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 AMEXOther

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 _____