|  |  |  |
| --- | --- | --- |
| Name: | | Today’s Date: |
| Address: | | Date of Birth:  Age: |
| City, State, Zip | Primary Phone: | Race/Ethnicity: Caucasian / African-American / Hispanic / Asian / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell/Work/Alternate Phone: | E-mail Address: | Marital Status: Single / Married / Divorced / Widowed |

**Stonebriar Counseling Associates – Pam C. Lyons, M.Ed, NCC, LPC-S, CPC**

**Client Initial Assessment**

|  |
| --- |
| **Your Reason(s) for Coming to Counseling** (Please briefly describe below.) |
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| --- |
| **Referral Information** |
| How did you hear about SCA/Pam C. Lyons (who referred you)? |
| Are you being required to come to counseling by anyone (probation, CPS, etc.)? YES NO  If YES, who? |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Your Counseling/Treatment History** (Please list any current or past counseling, psychiatric care, or substance abuse treatment.) | | | | | | | | | |
| Date | Provider | | Problem/Issue | | | Duration | | Outcome | |
|  |  | |  | | |  | |  | |
|  |  | |  | | |  | |  | |
|  |  | |  | | |  | |  | |
| **About Your Family** (Please provide the following information. *When noting relation, note step-, half-, adoptive, etc.*) | | | | | | | | | |
| Name | | Age | | Relation | In Home?  (Y/N) | | Living?  (Y/N) | | Substance Abuse  (Y/N) |
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| --- | --- |
| **Your School Information (for students only)** | |
| School Name/Location: | Current Grade Level: |
| Extra-Curricular Activities (i.e., band, sports, FFA, Student Council, Clubs, etc.): | |

|  |  |  |
| --- | --- | --- |
| **Your Employment Information** | | |
| Employer (If unemployed, list most recent employer): | | |
| City: | | |
| Currently Employed? Yes / No | Hours per Week: | Position: |
| |  | | --- | | **Your Spiritual Beliefs/Church Information** | | | |
| Describe your spiritual beliefs: | | |
| Church Membership:  Are you active? | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Information About Suicide/Self-Harm** | | | | | | | | |
| Have you ever thought about committing suicide? NO YES When/Explain: | | | | | | | | |
| Have you ever attempted suicide or hurt yourself? NO YES When/Explain: | | | | | | | | |
| Have you ever known anyone who committed suicide? NO YES When/Explain: | | | | | | | | |
| **Significant Life Events** (Indicate any that apply to you.) | | | | | | | | |
| Event/Situation | | YES or NO | | When/Who/Other Information | | | | |
| Death of a Parent | |  | |  | | | | |
| Divorce of Parents | |  | |  | | | | |
| Death of a Brother/Sister | |  | |  | | | | |
| Death of Other Family Member | |  | |  | | | | |
| Chronic Illness of Family Member | |  | |  | | | | |
| Multiple Moves | |  | |  | | | | |
| Loss of Good Friend(s) | |  | |  | | | | |
| Abandoned by Parent(s) | |  | |  | | | | |
| Chronic Illness/Hospitalization of Self | |  | |  | | | | |
| Struggles w/Sexual Identity/Orientation | |  | |  | | | | |
| Other: | |  | |  | | | | |
| **Information About Abuse** **You Have Suffered or Witnessed** | | | | | | | | |
| **Emotional -** Includes chronic discord between parents, yelling, screaming, cursing. YES NO  Explain: | | | | | | | | |
| **Physical -** Includes hitting (w/hands or other object); pushing; withholding food, water, sleep. YES NO  Explain: | | | | | | | | |
| **Sexual -** Includes words, looks, and touching: YES NO  Explain: | | | | | | | | |
|  | | | | | | | | |
| **About Your Substance Use History** (Complete the information and circle your drug of choice.) | | | | | | | | |
| Substance | AGE of First Use | | DATE of  Last Use | | Days Used in Past 30 Days? | Amount Used at a Time | Frequency of Use (How Often) | Method of Use (smoke, snort, IV, etc) |
| Alcohol |  | |  | |  |  |  |  |
| Marijuana |  | |  | |  |  |  |  |
| Amphetamines / Methamphetamines |  | |  | |  |  |  |  |
| Powder Cocaine |  | |  | |  |  |  |  |
| Crack Cocaine |  | |  | |  |  |  |  |
| Heroin |  | |  | |  |  |  |  |
| Other Opiates (Morphine, Methadone, Oxycontin, Hydrocodone, Codeine, Demerol, Dilaudid, Vicodin, Lorcet, Percodan) |  | |  | |  |  |  |  |
| Benzodiazapines (Sedatives, Anxiolytics, Xanax, Valium, Soma, Librium, Klonopin, Ambien, Versed, Restoril, Halcion, Sonata, Dalmane) |  | |  | |  |  |  |  |
| Ecstasy |  | |  | |  |  |  |  |
| GHB, Ketamine |  | |  | |  |  |  |  |
| DXM (Corecedin, cough syrup) |  | |  | |  |  |  |  |
| PCP |  | |  | |  |  |  |  |
| LSD, Mushrooms, or other hallucinogens |  | |  | |  |  |  |  |
| Inhalants |  | |  | |  |  |  |  |
| Steroids |  | |  | |  |  |  |  |
| Tobacco |  | |  | |  |  |  |  |
| Other Substances |  | |  | |  |  |  |  |

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| **Your Legal Status** | | | | | |
| Currently on Probation? YES NO | Probation Officer’s Name: | | | | |
| On Probation for: | | | | Scheduled end date: | |
| Arrests in past year: | | | Charges pending: | | |
| Charges Pending in Court? YES NO Explain: | | | | | |
| **Child Protective Services Status** | | | | |
| Current CPS Involvement? YES NO | | CPS Worker’s Name: | | | |
| If Yes, have your children been removed from the home? YES NO | | | | | |
| If Yes, whose care are the children in currently? | | | | | |
| If CPS is involved, please describe the circumstances: | | | | | |

|  |
| --- |
| **Your Interest in Counseling / Treatment** |
| On a scale from 1 to 10, how interested are you in receiving counseling services at this time ?  1 2 3 4 5 6 7 8 9 10  Not at Somewhat Very  all interested Interested Interested |

|  |
| --- |
| **Is There Anything Else You Want The Counselor To Know?** |
|  |

#### Personal Information

Church Membership \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you active? \_\_\_\_\_\_\_\_

Medical Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you?**

\_\_\_ New Life Radio Network \_\_\_\_ Fellowship Church

\_\_\_ SCA Web Site \_\_\_ Pastor (please give name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_ School (please give name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Physician (please give name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Family/Friend (please give name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Yahoo Yellow Pages \_\_\_\_ Allen Community Web Page

\_\_\_ Focus On The Family \_\_\_\_ McKinney Community Web Page

\_\_\_ Google Search \_\_\_\_ Blue Cross/Blue Shield Web Page

What drew you *most* to **Stonebriar Counseling Associates**? \_\_\_Church referral

\_\_\_ Christian Influence \_\_\_ Convenient Hours

\_\_\_ Convenient Location \_\_\_ Affordable Cost \_\_\_ Personal Referral

CLIENT INFORMATION AND CONSENT

**I WELCOME YOU! It is my desire to insure that your participation in counseling is a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information, which will enable you to make an informed consent to counseling.**

# Therapist

My name is Pam C. Lyons, M.Ed, NCC, CPC, LPC-S and I am a Licensed Professional Counselor –Supervisor (#69833) engaged in providing mental health care services to clients directly as an independent contractor/provider for Stonebriar Counseling Associates.

# Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future; 3) move toward resolving your concerns; and, 4) forge a life plan that promotes greater realization of your human potential, happiness, and success.

As your therapist, using my knowledge of human development and behavior, human change process, and Cognitive Behavioral Therapy, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if recommended by your therapist.

# Appointments

Appointments are made by calling 972-440-5286 Monday through Saturday between the hours of 9:00 A.M. and 5:00 P.M. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you experience a life threatening emergency please go to your nearest ER or call 911.

# Number of Visits

The number of sessions depends on many factors and will be assessed and discussed by the therapist.

# Length of Visits

Therapy sessions are 45-50 minutes in length but may take longer for testing assessment.

# Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship and abide by the ethical standards of the Texas State Board of Examiners of Professional Counselors (§ 681.32 Texas Administrative Code, Chapter 681), it is imperative that the therapist refrain from any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

# Cancellations

**Cancellations** must be received **at least 24 hours** before your scheduled appointment; otherwise **YOU will be charged the customary fee for that missed appointment**. You are responsible for calling to cancel or reschedule your appointment.

# Payment for Services

The charge for your sessions is **$100.00/hr**. Payment is expected at the time services are rendered. I accept personal checks and cash **and major credit cards**. If payment becomes a hardship for you, please discuss this with me so we can arrange a suitable payment plan. If I am listed as a provider for your insurance plan, I will collect your co-pay and file your insurance for you. For out of network plans, you will be provided a receipt so that you can file for insurance reimbursement. Insurance benefits usually cover only “medically necessary” treatment, requiring a mental health diagnosis. **Any diagnosis made will become part of your permanent insurance records and may have implications concerning future applications for life insurance, long-term care insurance, or future health coverage in the event of a change in health care plans**. If you have concerns regarding your diagnosis, please discuss these with me. **Within contract guidelines, the undersigned therapist will look to you for full payment of your account, and you will be responsible for payments of all charges including NSF Bank charges**. Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, **payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

###### COURT TESTIMONY

If requested to testify or be subpoenaed to appear in court, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ requires a minimum fee of $560.00 (4 hour minimum, billed at $130.00 an hour, and $60.00 travel expense), to be paid prior to the court appearance.  If he/she is required to be at court longer than 4 hours, the time will be billed at $130.00 per hour, including partial hours.

\*\*\* \_\_\_\_\_ **Please initial**

Please do the same for the **Intake and Consent Document...p. 3 Payment for Services/Insurance Filing...please erase: For legal proceedings that require me or my assistant Jennifer’s response, I bill $150 per hour** (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). **.**

**and insert the same :**

###### COURT TESTIMONY

If requested to testify or be subpoenaed to appear in court, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ requires a minimum fee of $560.00 (4 hour minimum, billed at $130.00 an hour, and $60.00 travel expense), to be paid prior to the court appearance.  If he/she is required to be at court longer than 4 hours, the time will be billed at $130.00 per hour, including partial hours.

\*\*\* \_\_\_\_\_ **Please initial**

# Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client’s written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of minors; abuse, neglect, or exploitation of the elderly; abuse of patients in mental health facilities (§681.33 TAC, Ch.681); criminal prosecutions (§611.004 Texas Health & Safety Code, Ch. 611); child custody cases (§ 611.006 Texas Health & Safety Code, Ch. 611); situations where the therapist has a duty to disclose, or where, in the therapist’s judgment, it is necessary to warn or disclose (§ 611.004 Texas Health & Safety Code, Ch. 611); fee disputes between the therapist and the client (§611.006 Texas Health & Safety Code, Ch. 611); or the filing of a complaint with the licensing board (§611.006 Texas Health & Safety Code, Ch. 611). If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this

matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you, and you are responsible for providing payment for services rendered, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

# Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

## Name Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

## Address Telephone Number

**Risks of Therapy**

Therapy is the Greek word for change. You may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of couple’s therapy is the possibility of exercising the dissolution option.

**After-Hours Emergencies**

Your therapist is on call and can be reached for emergencies by calling 972-440-5286 to be paged. If it is a life-threatening emergency go to the ER or call 911. Emergencies are urgent issues requiring immediate action.

# Therapist’s Incapacity or Death

I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice.

# Consent to Treatment

I voluntary agree to receive Mental Health assessment, care, treatment or services, and authorize the undersigned therapist to provide such care, treatment or services, as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment or services, and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample initial opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drivers License Number (s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone (s)

As Witnessed by

Therapist Date

***Permission for Professional Services for a Minor:***

I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Birth date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Birth date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_,

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent Date

***Client Family member signatures:***  All family members who are involved in this therapy need to sign below, indicating an understanding of these policies and procedures. If you have any questions, please discuss them with your therapist ***before*** you sign.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date

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Client Date

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Client Date

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Client Date

##### Witnessed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Date