Date:_____/_____/_____ **Fee Assessed: $**_____

Liz Casteel, M.A., LPC-S	***Ann Key, M.A., LPC-S***	***Allie Threlkeld, M.Ed., LPC***
Audrey Cook, M.A., LPC, NCC	***Elizabeth Mayfield-Pitts, M.A., LPC***	***Rachel Vendsel, M.A., LPC***
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NIKAO COUNSELING CENTER
Child Intake Information

Child's Name_____
Last First Middle

Home Address:_____
Street City State Zip

Phone:_____/_____/_____
Home Work Cell

Parent's Names: _____

If parents are divorced or deceased: Year Divorced _____ Year Deceased_____

Please list siblings (Clarify if living in home by "IN" beside name): (Circle)

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

_____ Age: _____ DOB ____/____/____ Gender ___ Biological / Step / Adopt

May I contact you via: Hm Phone: Yes___ No___ Wk Phone: Yes___ No___ Cell Phone: Yes_ __No___
May I leave a message on: Hm Phone: Yes___No___ Wk Phone: Yes___ No___ Cell Phone: Yes___ No_____

Person to contact in case of emergency:_____ Telephone:_____

Parent's email address:_____ Social Security #:_____-____-_____ DL#_____

Child's D.O.B.____/_____/_____ Age:____ Sex:____ Place of Birth:_____

School Child Attends: _____ Grade: _____

Parent's Employer:_____ Position _____

Child's Religion: _____

Nikao's full session fee is $130.00 per 50 minute session. If you are requesting our sliding scale, it is dependent on combined household income. Household income includes outside financial resources in addition to work income (i.e. investments, trust funds, benefactor support).

If you are requesting the sliding scale, please select the range of your combined household income

☐ Under $20,000 ☐ $20,000-40,000 ☐ $40,000-60,000 ☐ $60,000-80,000

☐ $80,000-100,000 ☐ Over $100,000

Referral Source: _____/_____

Name Address

If someone referred you to our office, I would like to thank him or her for the referral. May I have permission to send a thank you note? Yes_____ No_____

What is your major concern that led you to seek help?

_____

_____

_____

What other concerns do you have?

_____

_____

_____

Please answer "yes" or "no" and briefly describe any "yes" answers to the questions below.

Is your child consistently down or depressed mood most of the day or nearly every day? ____Yes ____ No

_____

Does your child have a diminished level of interest in most or all activities? ____ Yes ____ No

_____

Change in appetite? ____Yes ____ No _____

Change in weight? ____ Yes ____ No _____

Change in sleep pattern? ____ Yes ____ No _____

Fatigue or loss of energy? ____ Yes ____ No _____

Feelings of worthlessness or excessive guilt? ____ Yes ____ No_____

Difficulty thinking or concentrating? ____ Yes ____ No _____

Thoughts of death or suicide (or any attempts)?____ Yes ____ No _____

Increased irritability or violent behavior?____ Yes ____ No _____

Attacks of hyperventilation, palpitations or intense fear? ____ Yes ____ No _____

Any phobias or unusual fears? ____ Yes ____ No _____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)? ____ Yes ____ No _____

Height _____ Weight _____ Highest Weight _____ Lowest Weight _____

Any history of food binging? _____

Any use of laxatives, diuretics, diet pills, purging or food restriction? (Please circle and describe) _____

_____

Any history of excessive alcohol and/or drug use? (Briefly describe)

_____

_____

Has your child ever experienced any traumatic events? (Briefly describe)

_____

_____

Has your child experienced any academic difficulty? (Briefly describe)

_____

_____

Has your child ever been in therapy? (Give name of therapist, dates and describe issues that were discussed)

_____

_____

Has your child ever had any major medical problems (i.e. thyroid, diabetes, asthma, injuries etc.)?

_____

_____

Has your child ever had any prior hospitalizations (give date, reason, type of treatment)?

_____

_____

Is your child currently under the care of a physician and/or psychiatrist? If so, whom? And for how long?

_____

_____

Please list all medications he/she is currently or has recently taken. Give names, dosage and duration of usage.

_____

_____

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives. Indicate any who have had similar symptoms as your teen. Also, note if any had problems (even if no treatment was received) with the following: anxiety, depression, manic depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, etc.) Please note any other emotional or medical problems.

RELATIVE **PROBLEM**

_____

_____

_____

_____

Is there anything else that would be helpful for me to know about?

_____

_____

What do you hope or expect your child to gain from therapy?

_____

_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

PARENT'S SIGNATURE_____ DATE_____

CLIENT'S SIGNATURE_____ DATE_____

Nikao Counseling Center

17480 Dallas Parkway, Suite 231 ~ Dallas, Texas 75287
972.733.0050 (office) ~ 972.733.0049 (fax)

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NIKAO'S INFORM AND CONSENT

We are pleased that you have selected Nikao Counseling Center for your counseling needs. This document is designed to inform you about our office policies and to insure that you understand our professional relationship.

Nature of Counseling

We use an approach to counseling which takes into account the spiritual, psychological, social and biological dimensions of the client. The relationship we establish will be characterized by mutual respect and cooperation. Our mutual goal will be that you will grow, develop, and be committed to working on things we talk about both during our sessions and at home. Our ultimate goal is that you will come to a place of being able to resolve your own issues and/or live with manageable pain without our assistance or intervention. We will offer you tools in which you can utilize in the achievement of this goal.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads the client to having better relationships, solutions to specific problems, and significant reductions in feelings of distress. Please note, however, that it is impossible to guarantee any specific results regarding your counseling goals. Together, we will work to achieve the best results possible.

Confidentiality

The staff at Nikao Counseling Center operates as a team to improve the quality of counseling. Because of this, the process of your counseling may be discussed with your counselor's colleagues and/or your counselor's supervisor and will remain confidential. All counselors with the title "LPC-Intern" are supervised with weekly case reviews by Elizabeth Casteel, M.A., LPC, Texas Board Approved Supervisor. Everything that is communicated within our sessions is confidential information and cannot and will not be communicated to any other person or organization without your expressed written consent. This confidentiality applies to any and all records of your identity, diagnosis, session or progress notes, evaluation, treatment or treatment plan, as well as any information communicated by phone, fax, or email.

Please note: ***confidentiality will not be observed with respect to the following conditions:***

1. You direct me by means of a signed and dated written consent form to disclose information to a person or organization of your choice, (please note: if you enter therapy as a married couple, both signatures will be required in order to release confidential information),
2. I determine you are a danger to yourself or others, in which case I am required to inform a medical or a law enforcement agency,
3. I become aware of abusive or neglectful behavior toward a minor,
4. I become aware of abusive, neglectful, or exploitive behavior toward the elderly or disabled persons,
5. I am ordered by a court to disclose information,
6. I need to utilize the services of a collection agency for any unpaid balance (no clinical information will be provided, only contact information), or
7. I find it helpful to seek counsel from another mental health professional in order to help you more effectively seek recovery and emotional healthiness.

Initials:_____

I authorize my counselor to give out psychological information that is needed by my insurance company. This authorization for release is valid for the duration of the therapeutic relationship. I understand and agree that a diagnosis must be given and that diagnosis will become a pertinent part of my records. Initials:_____

Fee Agreement and Cancellation Policy

Sessions are 50 minutes in length. Payment is due at the conclusion of each session. We accept cash, checks, MasterCard/Visa. Please make checks payable to your therapist. The cost for therapy is based on a sliding scale dependent on your combined household income. To know more details, please talk directly to your therapist. Receipts will be provided after each session should you wish to file insurance. Due to variations in policies, we cannot guarantee payment by your insurance company. If you lose your receipt and need a copy, there will be a $.50 charge per receipt. In addition, a $25.00 fee will be charged for all returned checks.

Should you need to cancel your appointment, please call at least 24 hours in advance. Except for emergencies, the normal fee will be charged for missed appointments if not given 24 hours notice. (Voicemail is available 24 hours a day, seven days a week).

I understand that fees for all services are due at the time of my appointment. I also understand that the normal fee will be charged for missed appointments if my therapist is not given a 24 hour advance notice. Initials: _____

I understand that my therapist will utilize the services of Financial Management of Arlington, Texas to collect any unpaid balance over 90 days. Initials: _____

We wanted to make you aware that several days a week, Lola (silver Labrador Retriever), our Nikao therapy dog is in the office. She camps out mostly in Liz Casteel's office but at times you may see her in the checkout area or greeting people in the waiting room. If this is bothersome to you for any reason, please let your counselor know so that Lola can be kept in another office while you are here at Nikao. We would not want Lola to cause you to experience anxiety or discomfort in any way. Initialing below confirms that you are aware that Lola is in our office space. Initials: _____

In the Event of a Crisis or an Emergency

If you have an emergency, you can contact your therapist at 972-733-0050. Voicemail is checked daily Monday-Friday during regular business hours and calls will be returned as soon as possible. If you need to have your therapist paged immediately, you can call the above number and use the paging system, which is explained on the voicemail message. Please use discretion when paging your therapist. If for some reason you cannot reach your therapist, contact your local emergency room or police department when necessary and appropriate.

Your Signatures Below:

I have read and understand the above office policies. I have also been given a copy of the "Inform and Consent" document to retain for my personal files.

_____
Client Signature

_____
Signature of Parents / Legal Guardian if Client under 18 yrs of age (must have both parents' signature if applicable)

_____
Signature of Spouse (if participating in therapy)