

Date: ____/____/____

Fee Assessed: \$ _____

<i>Liz Casteel, M.A., LPC-S</i>	<i>Audrey Cook, M.S., LPC, NCC</i>	<i>Annalise Harness, M.A., LPC-Intern, LMFT Associate</i>
<i>Rachel Hopkins, M.A., LPC</i>	<i>Ann Key, M.A., LPC-S</i>	<i>Martha Ryan, M.Ed., LPC</i>
<i>Allie Threlkeld, M.Ed., LPC</i>	<i>Josh Walsh, M.A., LPC</i>	<i>Hazel, Therapy Dog</i>

NIKAO COUNSELING CENTER Adolescent Intake Information

Adolescent'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
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- _____ 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 ___

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

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

Parent's Employer: _____ Position _____

Religion as a child: _____ Currently: _____

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

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 _____

Nikao's session fee is \$140.00 per 50 minute session. If there is a financial need, please discuss with your individual counselor.

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 teen consistently down or depressed mood most of the day or nearly every day? ___ Yes ___ No

Does your teen 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 bingeing? _____

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 teen ever experienced any traumatic events as a child or young adult? (Briefly describe)

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

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

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

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

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

How much "screen time" does your teen have per day? (i.e. online, playing video games, using social media, watching television)

Which ones do they use the most? _____

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 teen 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

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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: _____

Technology

It is very important to be aware that computers, E-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent from our computers/phones/tablets are not encrypted. Nikao counselors only use computers that are equipped with a firewall, a virus protection and a password. Please keep this in consideration when using your computer/phone/tablet to communicate with our counselors. In addition, it is important for you to know that our office phone number is unable to receive text messages.

Initials: _____

Weather Policy

In the event of a weather emergency, we defer to DFW school districts. If local schools are closed, no fees will be collected for cancellations of counseling appointments. However, your counselor may still be willing to meet either in the office or offer a phone or Skype session if you would like. Your counselor will communicate with you regarding your appointment in the event of inclement weather.

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 \$140.00 per 50 minute session. If there is a financial need, 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, Hazel, our Nikao therapy dog will periodically be coming to the office to get acquainted with our counselors and our clients. 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 Hazel can be kept in another office while you are here at Nikao. We would not want Hazel to cause you to experience anxiety or discomfort in any way. Initialing below confirms that you are aware that Hazel 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)