ηikao counseling

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

Liz Casteel, M.A., LPC-S	***Audrey Cook, M.S., LPC, NCC***	***Annalise Harness, M.A., LPC, LMFT Associate***
Rachel Hopkins, M.A., LPC	***Ann Key, M.A., LPC-S***	***Martha Ryan, M.Ed., LPC***
Allie Threlkeld, M.Ed., LPC	***Josh Walsh, M.A., LPC***	***Marta Higbie, B.S., M.A. Candidate***
	Hazel, Therapy Dog	

Adult Intake Information

Name: _____
(Last) (First) (Middle/Maiden)

Home Address: _____
(Street) (City) (State) (Zip)

Phone: _____ / _____ / _____
(Home) (Work) (Cell)

May I contact you via: Home Phone: Yes☐ No☐ Work Phone: Yes☐ No☐ Cell Phone: Yes☐ No☐
May I leave a message on: Home Phone: Yes☐ No☐ Work Phone: Yes☐ No☐ Cell Phone: Yes☐ No☐

Email Address: _____ DL# _____

D.O.B.: _____ Age: _____ Sex: _____ Place of Birth: _____

Marital Status: S☐ M☐ D☐ W☐ If married, how long? _____ Spouse's Name _____

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

_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐
_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐
_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐
_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐
_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐
_____ Age: _____ DOB: _____ Gender : _____ Biological☐ Step☐ Adopted☐

Your Employer: _____ Position: _____

Faith Preference: _____

If you attend church, where: _____

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 describe any "yes" answers to the questions below.

Are you consistently down or do you have a depressed mood most of the day or nearly every day?
Yes ☐ No ☐

_____

Do you 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 ☐ food restriction ☐ ?(Please describe)

Do you or have you ever used recreational drugs? If yes, (briefly describe)

Do you drink alcohol? If yes, how many drinks on average per week? Do you believe you have a problem with alcohol? If yes, briefly describe.

Are you in a relationship and if you are in a relationship, please describe the nature of the relationship and months or years together?

If you feel comfortable answering this question…have you experienced any traumatic events? Briefly describe.

_____

_____

List any previous counseling experience: Name of counselor(s) and dates attended.

_____

_____

Any major medical problems (i.e. thyroid, diabetes, asthma, etc.)?

_____

_____

Any prior hospitalizations (give date, reason, type of treatment)?

_____

_____

Name of Primary Care Physician: _____

Physician's Phone: _____

Date of last medical evaluation: _____

Have you been under the care of a psychiatrist? If yes:

Name: _____

Phone Number: _____

Date of last medical evaluation: _____

Current medications being taken:

1)_____Dosage/Freq:_____Start Date:_____Purpose: _____

2)_____Dosage/Freq:_____Start Date:_____Purpose: _____

3)_____Dosage/Freq:_____Start Date:_____Purpose: _____

4)_____Dosage/Freq:_____Start Date:_____Purpose: _____

Prescribed by: _____

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 yourself. 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 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.

SIGNATURE _____ DATE _____

SPOUSE'S SIGNATURE _____ DATE _____
(if participating in therapy)

ηikao counseling

Liz Casteel, M.A., LPC-S	***Audrey Cook, M.S., LPC, NCC***	***Annalise Harness, M.A., LPC, LMFT Associate***
Rachel Hopkins, M.A., LPC	***Ann Key, M.A., LPC-S***	***Martha Ryan, M.Ed., LPC***
Allie Threlkeld, M.Ed., LPC	***Josh Walsh, M.A., LPC***	***Marta Higbie, B.S., M.A. Candidate***
	Hazel, Therapy Dog	

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 ensure 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: _____

Record Storage/Interruption of Services

In the unfortunate event of a counselor's death, incapacity, or the termination of their counseling practice, your records will stay in the custody of Nikao Counseling Center and you will be provided with recommendations for an appropriate referral.
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 cancelations 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 or email your counselor 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: _____

Nikao Counseling Center is not a Medicaid approved provider, therefore they cannot offer services to Medicaid recipients. I attest that I am not a Medicaid recipient.
Initials: _____

We wanted to make you aware that several days a week, Hazel, our Nikao therapy dog is at the office hanging around our clients and counselors. 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 and leave him/her a confidential voicemail at their extension. Please talk to your individual therapist about their protocol in returning phone calls after hours or on weekends. Some of our therapist's only work certain days of the week so may not be available to address your urgent issue. If you cannot reach your therapist, and it is a life-threatening situation, please call 911 when necessary and appropriate.

Complaints:

Services will be provided in a professional manner consistent with legal and ethical standards by the Texas State Board of Examiners of Licensed Professional Counselors and by the Texas State Board of Examiners of Marriage and Family Therapists. You have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist or any policies, please bring it to your therapist's attention so it can be resolved as quickly as possible. If a complaint is not resolved, the Texas State Board of Examiners of Licensed Professional Counselors can be reached at 1-800-942-5540 and the Texas State Board of Examiners of Marriage and Family Therapists can be reached at 1-888-963-7111.

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)