

## NEW CLIENT INFORMATION SHEET – for minor clients

Thank you for choosing **Elledge Counseling Associates** for your counseling needs. The following pages contain:

- Information on fees and counselor experience
- Intake and policy forms
- HIPPA forms
- Addresses and tips on finding the counseling offices

Please complete a set of intake and policy forms for each child who will be a client and bring them with you to your first appointment.

**If you are divorced, we will also need a copy of the most recent divorce decree documenting your right to seek counseling for your child(ren) before we can proceed with the appointment.**

If you have any questions, prior to your appointment, please feel free to call your assigned counselor. Again, thank you for choosing **Elledge Counseling Associates**. We look forward to meeting with you soon.

## **FEE SCALE AND COUNSELOR EXPERIENCE**

### **Fee Scale**

The fees for a 45-minute counseling session range in price from \$25-\$100 and are based on each counselor's education, experience, and office location.

### **Counselor Experience**

Licensed Professional Counselor (LPC) - an individual in the state of Texas who has completed a master's degree in psychology or counseling, passed the state exam, and completed 3,000 postgraduate hours of supervised counseling experience with clients.

Licensed Professional Counselor Intern (LPC Intern) – an individual in the state of Texas who has completed a master's degree in counseling or psychology, passed the state exam, and is currently working on the required 3,000 postgraduate hours of counseling experience with clients.

Graduate Student – an individual who is at the end of their master's degree program in counseling or psychology and is working on the required hours of supervised counseling experience to complete their graduate degree. They are under the direct supervision of their university professor and the director of ECA.

## FEE ACCOUNTABILITY AND FINANCIAL CONSENT STATEMENT

I am aware that I must cancel an appointment at least 24 hours before the scheduled appointment to avoid full financial responsibility for that session. It is my responsibility to call or text my counselor (day/night/weekend) to cancel my appointment.

I agree to the one-time charge or debit to my credit/debit card in the amount of my regular appointment fee following any missed session or appointment cancelled with less than 24 hours' notice. Elledge Counseling Associates is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **ECA**. If paying by cash, I will bring the exact amount. Counselors are unable to make change and the excess will be applied to my next session. I understand that if I choose to pay ahead for sessions, no refunds will be made for unused sessions.

If my check is returned for insufficient funds I agree to a one-time credit/debit charge to my card/account plus the NSF fee and a service charge. Elledge Counseling Associates is not required to notify me of this charge.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

If I do not return books/CD/DVD material(s) to my ECA counselor, I agree to the one-time charge or debit to my credit card/account in the amount of the replacement cost of the material(s) and credit card service fee. Elledge Counseling Associates is not required to notify me of this charge.

### **Credit /Debit Card Information:**

Name as it appears on the card \_\_\_\_\_

Credit/Debit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

Cardholder's Zip Code \_\_\_\_\_

List all client's names this card may be used for to make payment:

\_\_\_\_\_

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

### Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which “students, trainees, or practitioners in mental health” learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third-party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

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Printed Name of Client

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Date

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Signature of Client/Responsible Party

## NOTICE OF PRIVACY PRACTICES CON'T

### Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- “This is **Elledge Counseling Associates** calling”)
- The right to inspect and copy the information that we maintain about you. However, we *may deny an individual access*, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
  - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to *endanger the life or physical safety of the individual or another person*;
  - the information makes *reference to another person* (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
  - The request for access is made by the individual’s personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to *cause substantial harm to the individual or another person*.
  - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request within sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates 328 Pebblebrook**, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

## REQUEST TO PARTICIPATE IN COURT PROCEEDINGS

If I or my legal counsel requests or subpoenas any counselor from ECA to appear on my behalf, in a deposition or in court, I agree to pay that counselor for his or her time and expenses. Billable time will be compensated at the counselor's regular session fee rate per hour.

Billable time and expenses include:

1. Time spent by the counselor reviewing the case files and preparing for court testimony.
2. The drive time to and from the counseling office and the place of testimony.
3. Time spent waiting for their court appearance and testimony.
4. Any tolls, hotel or meal costs associated with the court appearance.

If I or my legal counsel requests or subpoenas treatment summaries or session attendance documentation on my behalf, I agree to pay my counselor's regular session fee per hour to research, copy and or complete requested materials. This includes information for all legal, disability or insurance purposes. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented.

**ECA counselors do not give legal advice so we strongly urge all clients to discuss with their lawyers the perceived need for a counselor's documentation, court testimony etc. and the subsequent financial burden it may cause to the client.**

**By signing below, you are stating that you have read and understood this policy statement and have had any questions about the policies and this document answered to your satisfaction.**

Client Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Client Signature \_\_\_\_\_

## INFORMED CONSENT AND ECA POLICIES

I consent to my child taking part in treatment with an **Elledge Counseling Associates (ECA)** counselor. I understand that the counselor will develop a treatment plan consisting of goals I have for my child, goals my child may have and those the counselor determines are in the best interest of my child.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I agree to talk with the counselor if I feel like ending therapy before all the treatment goals for my child are met.

Sessions last for 45 minutes. I also understand that if I or my child is late to an appointment the counselor will not run over into another client's appointment time and I will be billed for the entire session.

In the case of an emergency I may call my child's counselor. If the counselor is unavailable and it is a life-threatening emergency, I will call 911 or take my child to the nearest emergency room.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which surpass the confidentiality of the client-therapist relationship and the therapist may be ethically bound and legally required to inform the proper authorities.

Exceptions to Confidentiality:

1. The therapist makes an assesses that the client is a danger to self or others.
2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or mentally challenged person
3. A client acknowledges committing past or present abuse/neglect/exploitation of a child, elderly person, or mentally challenged person.
4. When counseling records are subpoenaed by a court of law.
5. The client shares with the counselor their use of pornography involving minors.

**By signing below, you are stating that you have read and understood this informed consent and policy statement and have had any questions about this document answered to your satisfaction.**

Parent/Guardian Printed Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## LIMITS OF THE COUNSELING RELATIONSHIP

It's important to remember that although the sessions with your counselor may feel very intimate emotionally or psychologically, the counseling relationship is a professional one and not a social one.

The counseling relationship is governed by certain laws and ethics that are set in place for your protection as a client.

For example:

1. Contact must be limited to sessions you schedule with your counselor.
2. Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).
3. Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.
4. When the counseling relationship ends, the limitations of contact with your counselor must remain the same.

I have read and understand the limits of the counseling relationship.

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Client Printed Name

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Date

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Parent/Guardian Signature



## Parent/Guardian Participation Agreement

Parents are the most important people in a child's life. We as counselors are here to support your child by providing a safe environment for him/her to process difficult emotions, thoughts and experiences. We will educate him/her on certain topics or provide coping tools and tips as appropriate. At times we will also be advocates for your child and ask you to work with us to see the improvement you and/or your child desire.

Some parent's mistakenly think that they will bring their child in for a 45-minute session every week or every other week and the counselor will work a miracle and solve all the problems their child has in two months. Unfortunately, that is unrealistic and allowing you or you child to believe that sets you both up for disappointment.

So, in order to set you both up for success, here's what we ask of you:

1. Regular, consistent and punctual attendance at appointments (weekly is best whenever possible)
2. Participation in educational and encouraging resources (fancy words for the homework that your child's counselor will assign you – articles, videos, activities, books, podcasts)
3. Patience (your child's problems probably didn't develop in a few weeks/months so understanding that solving them in that short of time probably won't happen, either)
4. Attend regular parent meetings with your child's counselor to discuss progress, setbacks and treatment goals
  - Parent sessions are open to both parents unless deemed otherwise by a judge.
  - Separate sessions for divorced parents are the norm.
  - Stepparents are welcomed into sessions with their spouses.
  - Grandparents are welcome to attend parent sessions if invited by the child's parent/guardian.

\_\_\_\_\_ I understand that participation in my child's therapy is essential to the best outcome.

\_\_\_\_\_ I am willing to follow the participation guidelines outlined above.

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Signature

## RIGHT TO SEEK COUNSELING FOR A MINOR

Please initial the statement that describes your legal right to seek counseling for the minor child named below.

\_\_\_\_\_ I am the child's biological /adoptive parent with full rights to seek counseling for my child.

\_\_\_\_\_ I am the child's legal guardian and have provided the necessary legal paperwork as proof.

\_\_\_\_\_ I am appointed by the court or CPS with rights to seek counseling for the child and have provided legal paperwork as proof.

If legal documentation required:

\_\_\_\_\_ I have provided legal documentation that I have the right to seek counseling for the minor child without joint consent by the child's other legal parent.

\_\_\_\_\_ I have provided the counselor with the most recent legal documentation of my rights to seek counseling for the minor child.

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Signature

**UNACCOMPANIED MINORS POLICY**

For the protection of all children and in agreement with our partner sites:

Please initial each policy and sign at the bottom acknowledging your understanding of this policy.

\_\_\_\_\_ Minors are not allowed to be unaccompanied in the office buildings for any reason.

\_\_\_\_\_ Minors are not allowed to wait unsupervised while their parent(s) are in session.

\_\_\_\_\_ Minor clients waiting for their session must be accompanied by a parent/guardian at all times.

\_\_\_\_\_ Minor clients age 10 years and under must have a parent or guardian remain in the building during their session.

\_\_\_\_\_ Parents of minor clients age 11 or older may leave the premises during their child's appointment but if they do, must return to the office by quarter after. Parents who are late picking up children from appointments may be charged a late fee equivalent to their session fee and may no longer be able to schedule appointments.

\_\_\_\_\_ Minor clients who drive themselves to session may remain unaccompanied while waiting on their counselor.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

ADOLESCENT INTAKE FORM

Date: \_\_\_\_\_

Adolescent's Name \_\_\_\_\_ Age: \_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: M/ F

Preferred name/nickname/pronoun? \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to Adolescent \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

If the adolescent's address is different from above please list it below and the circumstances of the living arrangement

\_\_\_\_\_

Email \_\_\_\_\_ May we contact you by email? \_\_\_\_Yes \_\_\_\_No

Cell \_\_\_\_\_ May we leave a message on your voicemail? \_\_\_\_Yes \_\_\_\_No

May we text you about appointments? \_\_\_\_Yes \_\_\_\_No

May we text your adolescent about appointments? \_\_\_\_Yes \_\_\_\_No

I understand that communication by voicemail, text or email cannot be guaranteed private communication. I accept the risks of such communication. \_\_\_\_Yes \_\_\_\_No

Your Marital Status:  Single  Married  Separated  Divorced  Widowed

Current Spouse's Name (if applicable) \_\_\_\_\_ Age \_\_\_\_ Years of Marriage? \_\_\_\_

Spouse's Phone (in case of emergency): \_\_\_\_\_

Are there difficulties within the marriage \_\_\_\_Yes \_\_\_\_No

**Names of your children**

First name	Last name	Age	Lives in your home
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time

Does the adolescent have another biological or adoptive parent not listed above? \_\_\_\_Yes \_\_\_\_No

If yes, please list name/contact information here:

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

Do you have concerns about the above adult participating in your child's therapy process? \_\_\_\_Yes \_\_\_\_No

Please list two other contacts in case of an emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICAL INFORMATION

How would you rate your child's current physical health?  Excellent  Good  Fair  Poor

Is he/she currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)?

Yes  No If yes, please explain: \_\_\_\_\_

Previous hospitalizations for medical reasons?  Yes  No

If yes, please explain: \_\_\_\_\_

Medical conditions or disabilities: \_\_\_\_\_

Learning or other disabilities not listed: \_\_\_\_\_

Please list all **non-psychiatric** medications: (over the counter or prescription):

Medication Dosage Frequency

Medication	Dosage	Frequency

Has your adolescent ever abused prescription or non-prescription drugs?

Yes  No If yes, which types? \_\_\_\_\_

Has either parent had any medical problems?

Yes  No If yes, which types? \_\_\_\_\_

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### COUNSELING AND PSYCHIATRIC INFORMATION

Has he/she had previous counseling?  Yes  No

If yes, please explain: \_\_\_\_\_

Name and location of counselor: \_\_\_\_\_

For what reason? \_\_\_\_\_ For how long? \_\_\_\_\_

What were the results? \_\_\_\_\_

Has he/she ever been diagnosed or treated for any type of mental illness?  Yes  No

If yes, which type? \_\_\_\_\_

\_\_\_\_\_ Has anyone in your family ever been diagnosed with or treated for any type of mental illness?  Yes

No

If yes, which type? \_\_\_\_\_

Has your child ever attempted to commit suicide or homicide?  Yes  No

If yes, how? \_\_\_\_\_

Is there a history of suicide in your nuclear or extended family?  Yes  No

If yes, who? \_\_\_\_\_

Is your child presently having thoughts of harming self or others?  Yes  No

If yes, who/how? \_\_\_\_\_

Please list all **psychiatric** medications:

Medication	Dosage	Frequency

Is your child currently seeing a physician or psychiatrist?  Yes  No

Physician's Name: \_\_\_\_\_ City, State: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist's Name: \_\_\_\_\_ City, State: \_\_\_\_\_ Phone: \_\_\_\_\_

### **FAMILY RELATIONSHIPS**

If the adolescent's parents are separated or divorced, how old was the adolescent when this occurred? \_\_\_\_\_

To which family member is your adolescent the closest?

\_\_\_\_\_

How does this adolescent get along with his/her brothers and/or sisters?

\_\_\_\_\_

Describe any special activities that you do with your

adolescent. \_\_\_\_\_

\_\_\_\_\_

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### **SCHOOL**

Name of School/City: \_\_\_\_\_ Grade: \_\_\_\_\_

Please describe any positive or negative changes your adolescent is experiencing in school:

\_\_\_\_\_

\_\_\_\_\_

When did you first notice these changes? \_\_\_\_\_

What is your adolescent's attitude toward school? \_\_\_\_\_

What are his/her major complaints about school? \_\_\_\_\_

Has he/she changed schools recently? If yes, when? \_\_\_\_\_

Does your adolescent get along with teachers and other students?  Yes  No

Please Explain: \_\_\_\_\_

\_\_\_\_\_

### **REASON FOR SEEKING COUNSELING**

What issues/behaviors/concerns have brought your adolescent to counseling today? Recent event?

\_\_\_\_\_

\_\_\_\_\_

Please rate the severity of your adolescent's issues/behaviors/concerns on the following scale.

Mild    Moderate    Severe    Totally Incapacitating

How are your child's concerns affecting you personally? Please check all that apply:

Home    Dating Relationship    Marriage    Children    Health    Job    Finances

Extended Family    Relationship with God    Other: \_\_\_\_\_

When did your child's present concerns begin to be a problem? \_\_\_\_\_

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### BEHAVIORS OF CONCERN

Please check how often the following behaviors occur.

- |                                      |           |            |               |                |
|--------------------------------------|-----------|------------|---------------|----------------|
| 1) Loses temper easily               | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 2) Argues with adults                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 3) Refuses adult's requests          | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 4) Deliberately annoys people        | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 5) Blames others for own mistakes    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 6) Easily annoyed by others          | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 7) Angry/Recently                    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 8) Spiteful/Vindictive               | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 9) Defiant                           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 10) Bullies/Teases others            | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 11) Initiates fights                 | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 12) Uses a weapon                    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 13) Physically cruel to people       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 14) Physically cruel to animals      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 15) Stealing                         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 16) Forced sexual activity           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 17) Intentional arson                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 18) Burglary                         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 19) "Cons" other people              | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 20) Runs away from home              | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 21) Truant at school                 | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 22) Doesn't pay attention to details | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 23) Several careless mistakes        | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 24) Does not listen when spoken to   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 25) Doesn't finish chores/homework   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 26) Difficulty organizing tasks      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 27) Loses things                     | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 28) Easily distracted                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 29) Forgetful in daily activities    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 30) Fidgety/squirmy                  | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 31) Difficulty remaining seated      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 32) Runs/climbs around excessively   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 33) Sexually Active                  | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |

- |                                |                                |                                 |                                    |                                     |
|--------------------------------|--------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| 34) Hyperactive                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 35) Difficulty awaiting turn   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 36) Interrupts others          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 37) Problems pronouncing words | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 38) Poor grades in school      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 39) Expelled from school       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 40) Drug abuse                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 41) Alcohol consumption        | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 42) Depression                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 43) Shy/avoidant/withdrawn     | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 44) Suicidal threats/attempts  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 45) Fatigued                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 46) Anxious/nervous            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 47) Excessive worry            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 48) Sleep disturbance          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 49) Panic attacks              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 50) Mood shifts                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

What are the top three behaviors that you would like to see changed?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

### STRENGTHS/WEAKNESSES

List his/her three greatest weaknesses or needed areas of improvement.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

List his/her three greatest strengths.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

### SOLUTIONS

What, if any solutions have you tried for helping your adolescent overcome his/her current issues?

Are there any religious/spiritual or cultural concerns or information that would be important for me to know?



## ADOLESCENT SELF-REPORT

Your counselor wants to know what concerns or issues are important to you. If you want to fill this out and bring it to your appointment, please do. But no pressure! If you want to wad this up and throw it in the trash, go ahead 😊 You counselor is looking forward to meeting you and hearing from you.

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Birthday \_\_\_\_\_

Do you have a preferred name/nickname/pronoun? \_\_\_\_\_

School \_\_\_\_\_ Job \_\_\_\_\_

Hobbies \_\_\_\_\_

Who do you currently live with? \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

### THOUGHTS CHECKLIST

Please check how often the following thoughts that occur to you:

- |                                |           |            |               |                |
|--------------------------------|-----------|------------|---------------|----------------|
| 1. Life is hopeless.           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 2. I am lonely.                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 3. No one cares about me.      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 4. I am a failure.             | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 5. Most people don't like me.  | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 6. I want to die.              | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 7. I want to hurt someone.     | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 8. I am so stupid.             | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 9. I am going crazy.           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 10. I can't concentrate.       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 11. I am so depressed.         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 12. God is disappointed in me. | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 13. I am disappointed with God | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 14. I can't be forgiven.       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 15. Why am I so different?     | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 16. I can't do anything right. | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 17. People hear my thoughts.   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 18. I have no emotions.        | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 19. Someone is watching me.    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 20. I hear voices in my head.  | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 21. I am out of control.       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |

### ISSUES CHECKLIST

Please indicate which of the following are **current** issues for you. Check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Not being able to say what you really think or feel | <input type="checkbox"/> Feeling inferior to others                   |
| <input type="checkbox"/> Under too much pressure and feeling stressed        | <input type="checkbox"/> Angry outbursts                              |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood              | <input type="checkbox"/> Excessive fear of specific places or objects |

- Excessive anxiety or worry
- Withdrawing from others
- Suspicious feelings toward other people
- Afraid of being on your own
- Angry feelings
- Concerns about finances
- Feeling “numb” or cut off from emotions
- Concerns about physical health
- Concerns about emotional stability
- Tremors
- Blackouts or temporary loss of memory
- Insomnia (not being able to sleep)
- Loss of appetite/increased appetite
- Uncontrollable anxiety or worry
- Lacking selfconfidence
- Feeling sexually attracted to members of your own sex
- Eating and then vomiting to control weight
- Excessive use of alcohol
- Abuse of nonprescription drugs
- Loss of interest in usual activities/lack of motivation
- Heart Palpitations
- Other: \_\_\_\_\_
- Difficulty making friends
- Difficulty keeping friends
- Feeling as if you’d be better off dead
- Feeling manipulated or controlled by others
- Difficulty making decisions
- Loss of interest in sexual relationships
- Feeling Fat
- Feeling distant from God
- Hallucinations
- Hypersomnia (sleeping all the time)
- Inability to concentrate while at school/work
- Crying spells
- Feeling “on top of the world”
- Nightmares
- Getting into trouble at school/work
- Obsessions or compulsions with specific activities
- Inability to control thoughts
- Feeling trapped in rooms/buildings
- Hearing voices
- Feeling that people are “out to get you” or that you are being watched
- Memory Problems
- Chest Pain/Pressure

**PROBLEMS CHECKLIST -**

Rate Each Issue with a Number: 1 = Major Problem      2 = Problem at Times      3= Not a Problem

- \_\_\_\_\_ Feeling accepted by my peers
- \_\_\_\_\_ Learning how to trust others
- \_\_\_\_\_ Getting along with my parents or other family members
- \_\_\_\_\_ Getting a clear sense of what I value
- \_\_\_\_\_ Dealing with sexual feelings and/or problems
- \_\_\_\_\_ Worrying about my future
- \_\_\_\_\_ Trying to decide on a career
- \_\_\_\_\_ Dealing with alcohol or drug abuse
- \_\_\_\_\_ Dealing with problems at school

\_\_\_\_\_ Dealing with how I feel about myself

Other problems I'd like to talk about:

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What do you hope to gain from counseling?

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**STRENGTHS AND HELPS**

What personal strengths do you feel you possess that may help you with your current difficulties?

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Who or what has helped you cope with your current difficulties?

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Who or what has helped you cope with past difficulties?

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**ANYTHING ELSE**

If there is anything else that you want to remember to ask your counselor or that you want to talk about please write it here.

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## DIRECTIONS TO OUR LOCATIONS

### **Red Oak**

320 E. Ovilla Rd., Red Oak, TX 75154

We are located in the offices of First Baptist Red Oak. A brick electronic sign will mark the entrance to the FBRO campus and the church offices are located to the side of the sanctuary building. You may use the office parking lot and either wait on the front steps or in your car. Your counselor will be with you as soon as possible.

### **Waxahachie**

210 YMCA Dr., Waxahachie, TX 75165

We are located in The Avenue church offices (not the sanctuary). From Hwy 77/Ferris Avenue turn west onto YMCA drive and follow it to the **dead end**. The church office building will be on the right. Please ring the buzzer to the right of the front door and your counselor will be with you as soon as possible.

### **Ferris**

304 W 5th St., Ferris, TX 75125

We office inside the First Baptist Ferris/CenterPoint church. To reach the church offices you will **enter under the awning**. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

### **Ennis**

1200 Country Club Rd., Ennis, TX 75119

We office inside Tabernacle Baptist Church. Upon entering the parking lots look for the covered driveway entrance. Park there and you may wait outside by the door or in your car and your counselor will come for you as soon as possible.

### **Duncanville**

227 W. Center St., D'ville, TX, 75116

Our offices are in a white house with a red door, surrounded with a large porch and big trees. A sign in the yard will say, "Project Duncanville." The door may be locked if your counselor is with another client. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

### **Desoto**

50 W. Pleasant Run Rd., Desoto, TX 75115

We office inside Windsor Park Baptist Church. Park in the front left parking lot and enter through the doors by the "Office" sign. If the entrance is locked, ring the doorbell on the right side of the door and someone will open the door for you.

### **Mansfield**

2271 Matlock Rd., Mansfield, TX 76063

Our offices are located within Living Church. Your counselor will give you specific directions for entry

### **Mesquite**

2600 Eastglen Blvd. Mesquite, Tx 75181

The counseling offices are located within New Community Church. Your counselor will give you specific directions for entry

### **Arlington**

5950 S Collins St, Arlington, TX 76018

We office inside The Grace Place Church offices. Your counselor will give you specific directions for entry.