Intake Form

dr stephanie cook, lpc

	Client Name	Date	
	Address	Email	
	Zip Code	Client Contact Number	
	Responsible Party	Phone Number	

Describe your goals for counseling and what prompted you to begin?

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Recent Factors

• Any suicidal thoughts	**Yes**	**No**
• Depression or sadness	**Yes**	**No**
• Sleep problems	**Yes**	**No**
• Change in appetite	**Yes**	**No**
• Change in grades	**Yes**	**No**

Is there a divorce decree on file regarding minors?	**Yes**	**No**
Any pending court cases involving anyone in the home?	**Yes**	**No**
Any recent changes for anyone in the home (health, jobs, moves)?	**Yes**	**No**

Mothers Name	Sibling(s) Name/Age
Occupation	Sibling(s) Name/Age
Fathers Name	Other
Occupation	Other

Informed Consent

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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, we have set forth certain information which will enable you to make an informed consent to counseling.

EDUCATION:
BS Psychology, BS in Biblical Studies, MA in Counseling Psychology, Certification in School Counseling, Doctorate in Education

THERAPY/EVALUATION:
Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek help. As a collaborative process, therapy requires your efforts, honesty, and openness in order to achieve desired changes.

The therapeutic process can cause discomfort or strong feelings of anger, sadness, worry, fear, and so forth. Change will sometimes be easy and swift; other times it will be slow and even frustrating. There is no guarantee that therapy will yield the intended results. We will assess this throughout the process.

Where my main theoretical approach is the Adlerian Counseling theory I also use Cognitive Behavioral Theory to assess presenting problems to determine a treatment plan. During the course of therapy, I am likely to draw on various therapeutic approaches according, in part, to the problems that are being treated and my assessment of what will best benefit you. The techniques used may include homework and psycho-educational approaches.

FEES:
Our sessions will be 50 minutes long at $60 per session. Together, we will decide how often you should come. Payment is required at the time each session. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. In case of a missed session without the minimum 24 hours advanced notice, you will be billed for $60. Exceptions will be made, of course, in emergency situations. At this time we accept cash and online payment

By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services to you or your child and agree to pay them at the time of service. Future sessions will not be held if payment is missed. If rates should increase in the future, I will advise you at least 30 days prior to the increase.

Should legal actions occur in which I am requested or subpoenaed to provide testimony you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case and even if our relationship has ended:

1. Travel expenses
2. Hourly or per diem fees
3. Fees for the time expended in preparation and research
4. Record copying fees

OUR RELATIONSHIP:
This is a professional and therapeutic relationship. In order to preserve the integrity of the relationship, it is imperative that I not have any other type of relationship with the client. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I cannot accept gifts from you or your child, barter or trade services. In public, I cannot acknowledge you/your child unless you/your child first acknowledge me. In that case, there cannot be any conversation of a clinical nature between us.

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REFERRALS:
If at any time for any reason you are dissatisfied with my services, please let me know. Should you and/or I believe a referral is needed, I will offer suggestions on referrals. You are in complete control and may end our counseling relationship at any point. If you do decide to terminate, please notify me in advance, as it is best to properly terminate the relationship.

EMERGENCIES:
You can reach me on my cell 817-808-4600 during business hours. After hours, in the event of a genuine emergency, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

RECORDS AND CONFIDENTIALTY:
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 include but are not limited to the following:

1. The therapist determines any indication of physical, sexual or emotional abuse or illegal neglect of children, or abuse, neglect or exploitation of elderly or disabled persons.
2. The therapist determines you or your child is a danger to self or others.
3. The therapist is ordered by the court to disclose information.
4. You (client, parent or legal guardian) sign a written consent.
5. If you or your child receives concurrent services from another practitioner, we are both obligated to disclose our involvement to one another.
6. The therapist learns of sexual exploitation by another mental health services provider.
7. The therapist receives supervision and/or consultation to provide you with quality care (names will not be disclosed in this instance).

In the event of my death, your records will be forwarded to another professional selected by you.

All communication becomes part of the clinical record.

I have read the preceding information and understand my rights and responsibilities as a client.

	Client Signature	Date
	Guardian Signature	Date
	Therapist Signature	Date