

# COUNSELING CENTER OF LAKE POINTE

Confidential Client Intake Information

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Tammy Smith, M.A., L.P.C. – Intern  
Elizabeth Davis, M.A., L.P.C.

Date \_\_\_\_\_

**Basic Client Information**

Full Name: \_\_\_\_\_ Address: \_\_\_\_\_ May we contact using:  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  yes  no  
 Work Phone: \_\_\_\_\_ Cell Phone/Text: \_\_\_\_\_  yes  no  
 Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_  yes  no  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  male  female

Spouses Name: \_\_\_\_\_ Address: \_\_\_\_\_ May we contact using:  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  yes  no  
 Work Phone: \_\_\_\_\_ Cell Phone/Text: \_\_\_\_\_  yes  no  
 Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_  yes  no  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  male  female

Emergency Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

Are you a member of Lake Pointe Church? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you currently attend a church? \_\_\_\_\_ yes \_\_\_\_\_ no

What is your relationship status? (please circle)

Married \_\_\_\_\_ years

single divorced separated widowed married relationship remarried

Please list any children of yours.

1.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
2.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
3.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
4.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
5.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
6.	Age:	Step: <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? <input type="checkbox"/> yes <input type="checkbox"/> no	Gender: <input type="checkbox"/> male <input type="checkbox"/> female

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: \_\_\_\_\_ Spouse Initials: \_\_\_\_\_

**Your Signatures Below:**

I have read and understand the 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 Spouse (if participating in therapy)



701 Interstate 30, Rockwall, Texas 75087  
Office: 469.698.2250

## PATIENT SERVICES AGREEMENT

This Agreement contains information about privacy and patient rights. As required by law, your Notice of Privacy Practices for use and disclosure of Private Health Information (PHI) is available from our office. The law requires that we obtain your signature acknowledging that you were provided this information. Your signature represents a revocable agreement between us. A written revocation will be binding on us unless Lake Pointe Counseling has taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**PSYCHOTHERAPY SERVICES:** The nature of Psychotherapy varies depending on the personalities of the therapist and patient. In order for the therapy to be successful, you will have to work on things talked about both during sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. However, benefits of psychotherapy include better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Your therapist will evaluate your needs and offer treatment recommendations. You can discuss any questions you may have. If you have persistent doubts, your therapist will help you get a second opinion.

**MEETINGS:** Psychotherapy sessions consist of one 45 to 50-minute session. **Once an appointment hour is scheduled, you will be expected to give 24 hours advance notice of cancellation or pay a missed appointment fee. Please note that insurance companies do not pay for cancelled sessions.**

**PROFESSIONAL FEES:** The fee is \$85 per client session. The fees you pay may differ. If you require your doctor's or therapist's participation in legal proceedings, you must pay for all of the professional time including preparation and transportation costs. **There is a fee for returned checks.**

**CONTACTING THERAPIST:** After business hours, we provide an answering machine on which you can leave a note or page for emergency calls. We try to return your call on the same day you make it, with the exception of weekends and holidays. If you have paged for an emergency, and you are unable to reach therapist and feel that you can't wait for a return call, contact your family physician, 911, or the nearest hospital emergency room.

**LIMITS ON CONFIDENTIALITY:** The law protects communications between a patient and a mental health provider. Typically, information about your treatment is only released to others if you sign a written authorization form. This signed agreement provides consent for the following:

- Your therapist may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your therapist feels that it is important to your work together.
- Your therapist practices with other mental health professionals and Lake Pointe Counseling employs administrative staff. In most cases, your therapist needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient seriously threatens to harm himself/herself, your doctor or therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where your therapist may disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, such information is protected by law. Your therapist cannot provide any information without your (or your legal

representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency requests information for health oversight activities, we may be required to provide it.
- If a patient files a complaint or lawsuit against a therapist of Lake Pointe Counseling, your therapist may disclose relevant information regarding that patient for the purpose of legal defense
- If a patient files a worker's compensation claim, your therapist must, upon request, provide records relating to treatment or hospitalization for which compensation is being sought. **INITIALS** \_\_\_\_\_ **Spouse INITIALS** \_\_\_\_\_

There are some unusual situations in which your therapist is legally obligated to take actions necessary to protect others from harm and may have to reveal some information about a patient's treatment.

- If your therapist believes that a child has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, a report must be made to the appropriate governmental agency. Your therapist may then be required to provide additional information.
- If a therapist believes that the patient will inflict imminent physical, mental, or emotional harm upon him/herself, or others, the therapist may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, or therapist will make every effort to discuss it with you before taking any action and will limit disclosure to what is necessary.

**PROFESSIONAL RECORDS:** Protected Health Information about you is kept in two sets of records. Your Clinical Record includes information about your reasons for seeking therapy, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone, including reports to insurance carriers. Typically, you may examine and/or receive a copy of your Clinical Record. If your therapist refuses your request for access to your Clinical Record, you have a right of review. Psychotherapy Notes assist your therapist in providing treatment. They contain the sensitive information that you may reveal. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless your therapist determines that release would be harmful to your physical, mental or emotional health.

**PATIENT RIGHTS:** You have some rights regarding your protected health information including requesting that your therapist amend your record; requesting restrictions on what is disclosed to others; requesting an accounting of most disclosures of protected health information that you have not authorized; determining the location to which protected information disclosures are sent; having complaints about your therapist's policies and procedures recorded in your records; and a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures.

**MINORS & PARENTS:** The law allows parents to examine a minor child's treatment records unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse. Because privacy is often crucial to success, your therapist will typically provide parents only with general information the child's treatment. Before giving parents any additional information, the therapist will discuss the matter with the child.

**PAYMENTS:** **Payment is due at each session, unless we agree otherwise.**

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.**

**A copy of this document is available upon your request or accessible at [www.lakepointe.org](http://www.lakepointe.org) .** Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Client or Parent/Guardian **SIGNATURE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

If the patient is under age or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian. If the agreement is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

Date \_\_\_\_\_

## ***LIFE FUNCTIONING INVENTORY***

This form is intended to help your counselor become better acquainted with you and in turn, serve you better. Please print the information requested or checkmark the appropriate responses. You may omit any item, but try to be as thorough as possible. Thank you.

### ***Presenting Problem Analysis***

**1. Briefly describe the problem or concern you most wish help with currently:**

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**2. How would you rate the intensity of the problem or concern that led you to seek professional services?**  
(please circle)

Extremely Intense

Moderately Intense

Not Intense

**3. Approximately how long have you had the current problem or concern?** \_\_\_\_\_

**4. In what ways have you attempted to cope with this problem or concern?** \_\_\_\_\_

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**5. Please check any past, present, or impending problems/issues in your family:**

deaths  physical/sexual abuse  divorce

financial crisis/unemployment  frequent relocations  legal problems

debilitating injuries/disabilities  attempted/completed suicide  alcohol/drug abuse  eating disorders

serious/chronic illness  psychiatric disorder  marital affairs/infidelity  other \_\_\_\_\_

**Please specify family member(s), which problem/issue, and approximate year of occurrence.**

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### ***Health and Social Issues***

**1. How is your physical health at present?**  poor  fair  satisfactory  good  excellent

**2. Please list any persistent physical symptoms or health concerns** (e.g., chronic pain, headaches, diabetes, etc.)

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**3. Please list any prescribed medications you are presently taking.**

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**4. Are you having any problems with your sleep habits?**  yes  no **If yes, check where applicable:**

sleeping too little  sleeping too much  poor quality sleep

disturbing dreams  other \_\_\_\_\_

**5. Are you having any difficulty with appetite or eating habits?**  yes  no **If yes, check where applicable:**

eating less  eating more  binge eating

restricting calories  significant weight change (in past two months)

6. Do you regularly use alcohol? yes no

In a typical month, how often do you have 4 or more drinks in a 24 hr. period? \_\_\_\_\_

7. Have you ever tried to cut down on the amount of alcohol you consume? yes no

8. Has anyone close to you ever been annoyed by your drinking? yes no

9. Do you consider your alcohol consumption to be a problem? yes no unsure

10. How often do you engage in recreational drug use? daily weekly monthly rarely never

11. Do you consider this drug use to be a problem? yes no unsure

12. Have you ever experienced legal problems? yes no Nature of problem: \_\_\_\_\_

13. In the past, how would you rate the quality of your peer relationships?

very poor unsatisfactory average good excellent

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### *Mental Health History*

1. Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? yes no

2. Have you ever had previous counseling or psychotherapy? yes no If yes, please specify the following:

Reason for counseling: \_\_\_\_\_

Counseling location: \_\_\_\_\_

Counseling date: \_\_\_\_\_

Counseling duration: \_\_\_\_\_

3. Have you ever been hospitalized for psychiatric reasons? yes no

If yes, please specify the following: Reason for hospitalization: \_\_\_\_\_

Hospital location: \_\_\_\_\_

Dates of hospitalization: \_\_\_\_\_

Duration of hospitalization: \_\_\_\_\_

4. Have you ever been prescribed medication for psychiatric reasons? yes no

If yes, please specify the following: Name/dose of medication: \_\_\_\_\_

Date of prescription: \_\_\_\_\_

Duration of medication: \_\_\_\_\_

Physician who prescribed medication: \_\_\_\_\_

5. Have you had suicidal thoughts recently? yes no How often? daily weekly monthly rarely

Have you had them in the past? yes no How often? daily weekly monthly rarely

6. Have you ever intentionally inflicted harm upon yourself? yes no

How often? daily weekly monthly rarely Nature of harm: \_\_\_\_\_

7. Have you ever experienced any form of traumatic experience? yes no When? \_\_\_\_\_

Nature of experience: \_\_\_\_\_

9. Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

frequently a few times once never unsure

10. How does the future look to you? poor fair neutral good excellent

11. Please describe your future plans.

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

12. What do you hope to accomplish through counseling?

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

13. Is there anything else you would like your counselor to know about you?

\_\_\_\_\_

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**Your Signatures Below:**

I have read and understand the 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 Spouse (if participating in therapy)