# JOURNEY ON COUNSELING
## YOUTH INFORMATION FORM
## (PLEASE PRINT)

### CLIENT INFORMATION

Primary Client ______________________________________________
Last Name First Name MI Nickname

Address ______________________________________________
Street City State Zip

Home Phone ___________ Cell Phone ___________ Email ________________
Date of Birth ______________ Age _______ Gender ___________

May we leave a message at your home? _____ Yes _____ No

Name of other family members:
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________
________________ Age ____ Gender ____ Relationship ____________

### GUARDIAN'S INFORMATION

______________________________________________
Name Relationship
Home Phone _____________ Work _______________ Cell _____________
Email ______________________________________________
Date of Birth ________ Age _____ Occupation ____________________
May we call you at your home? _____ Cell? _____
May we leave a message at your home? _____ Cell? _____

______________________________________________
Name Relationship
Home Phone _____________ Work _______________ Cell _____________
Email ______________________________________________
Date of Birth ________ Age _____ Occupation ____________________
May we call you at your home? _____ Cell? _____
May we leave a message at your home? _____ Cell? _____

Parents' Current Marital Status (if need to differentiate, then please put an F for Father and M for Mother):
___ Never Married ___ Married ___ Engaged ___ Divorced
___ Separated ___ Widowed ___ Remarried
Date of Marriage (if applicable) ______________________________
Date of Divorce (if applicable) ___________ Date of Death (if applicable) ___________
Parents' Education Level (please put an F for Father and M for Mother):
_____ GED _____ High School Diploma _____ College Degree _____ Graduate Degree

Other important family info: ______________________________________
______________________________________________

**PERSONAL INFORMATION** (to be filled out by parent or guardian regarding youth)

Are you currently attending a church? ____ Yes ____ No
If yes, what is the name of the church? ______________________________________________
What is the denomination of the church? ______________________________________________
Do you have a personal relationship with Christ? ____ Yes ____ No ____ Unsure
Are religious or spiritual issues important in your life? ____ Yes ____ No
Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No
If yes, what are they? ______________________________________________
Would you like prayer as part of your counseling? ____ Yes ____ No
Who referred you to our center? ______________________________________________
May we contact them? ____ Yes ____ No
How would you rate your health? ______________________________________________
How many hours do you sleep each night? ______________________________________________
How would you rate your diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do you have any addictive/abusive issues? ____ Yes ____ No
If so, with what? ______________________________________________
Has your appetite or weight changed lately? ______________________________________________
Are you currently on medication? ____ Yes ____ No
If so, please complete the following:

| Medication | Dosage | Physician | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**PERSONAL CONCERNS**

Briefly explain why you are coming to counseling and what you hope to gain from your experience. ______________________________________________
______________________________________________
How much are you troubled by this?
____ Constantly ____ Often ____ Somewhat ____ Not Very Much
Comments concerning this problem: ______________________________________________
______________________________________________
Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? ______________________________________________
   What was the problem? ______________________________________________
   How many sessions over what period of time? ______________________________________________
   What were the results? ______________________________________________
2. Who was the counselor? ______________________________________________
   What was the problem? ______________________________________________
   How many sessions over what period of time? ______________________________________________
   What were the results? ______________________________________________
3. Who was the counselor? ______________________________________________
   What was the problem? ______________________________________________
   How many sessions over what period of time? ______________________________________________
   What were the results? ______________________________________________

## THOUGHTS AND BEHAVIORS

Parent or Guardian, please check how often you think the following thoughts occur for your child. Feel free to get their input or leave any blank that are not applicable.

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 can't be forgiven. ____ Never ____ Rarely ____ Sometimes ____ Frequently
14. Why am I so different? ____ Never ____ Rarely ____ Sometimes ____ Frequently
15. I can't do anything right. ____ Never ____ Rarely ____ Sometimes ____ Frequently
16. People hear my thoughts. ____ Never ____ Rarely ____ Sometimes ____ Frequently
17. I have no emotions. ____ Never ____ Rarely ____ Sometimes ____ Frequently
18. Someone is watching me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
19. I hear voices in my head. ____ Never ____ Rarely ____ Sometimes ____ Frequently
20. I am out of control. ____ Never ____ Rarely ____ Sometimes ____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated ____
Mood swings (depression-manic) ____
Excessive guilt or shame ____
Loss of energy ____
Loss of interest in activities ____
Suicidal thoughts ____
Suicide attempts (how many) ____
Lying ____
Manipulation ____
Poor impulse control ____
Hyperactivity ____
Change or loss of friends ____
Self-mutilation, cutting ____
Eating disorders ____
Excessive stress ____
Anxiety or excessive fears ____
Learning disabilities ____
School related problems ____
Hallucinations, delusions, thought distortions ____
Obsessive thoughts &/or compulsive behaviors ____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

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**EMERGENCY CONTACT**
Whom should we contact in case of emergency?

Name ___________________________________________________________________
Address _________________________________________________________________
Home Phone ___________________________ Cell Phone _____________________________

## INFORMED CONSENT

**COUNSELING RELATIONSHIP**

We appreciate the fact that you have chosen us to walk with you through the counseling process. We recognize that your participation is voluntary and know that you have the right to terminate at anytime. However, our goal for you is for full participation so that you may gain the most out of the counseling process. This includes consistent attendance, being on time and ready to go at the start of each session with your homework already completed. We trust that your commitment to these essentials of counseling will help play a valuable role in bringing about the change that you so desire.

Furthermore, we are completely committed to walking alongside you as you seek out change from a biblical perspective that ultimately draws you closer to God. As part of that commitment, it is extremely important to note that God is the only one that can and will cause true change. Our hope is not in ourselves or a technique but our hope is in the Lord to work through us and in your heart in order to cultivate genuine Christ-like change.

**COUNSELING APPROACH**

The counselor takes a Cognitive-behavioral approach from a Biblical foundation. Most of the counseling process will focus around change coming from this perspective. The related risk follows if the client does not see change from this perspective and then proceeds to move forward with counseling. It is important to note that even though we believe strongly in incorporating Scripture and prayer in the counseling session, we will not impose our beliefs on the client that does not share this same value.

**CONFIDENTIALITY**

We are obligated legally and ethically to keep any of the information that you share with us private and confidential. Limits to confidentiality are listed below:

- The counselor determines the client is a danger of harming himself/herself or someone else.
- The client discloses abuse or neglect of a child, elderly or disabled person.
- The client authorizes the counselor to release records.
- The counselor or counseling records are summoned or subpoenaed by a court of law.
- The counselor becomes aware of an ethical violation by another mental health professional.

**APPOINTMENTS**

We will make a special effort to make sure that the counseling sessions start on time. As a result, it is our expectation that you will share this expectation with us which will help start and end sessions on time. Here are a few important things to know about your appointment:

- Each appointment is typically 50 minutes long. Together, the client and counselor will make decisions concerning how often and for how long they should meet.
- In case you are running late to an appointment, please call but know that your appointment will still end at the specified time.
- In case an appointment needs to be canceled or rescheduled, please be courteous to give your counselor a 24 hour notice. Together, the client and counselor will make decisions concerning how often and for how long they should meet.
- Please make sure that all cell phones are turned off during the session to maximize the time allowed for counseling. The counselor will adhere to this policy as well.

**AFTER HOURS/EMERGENCIES**

Counseling hours are Monday through Friday 8am to 6pm. In case of an emergency after hours please call your primary care physician, 911, your local hospital, or a suicide hotline: 214-828-1000 or 972-588-4007 for assistance during office hours. Please know that we will make every effort to return messages and emails the next business day for calls received after work hours or during the weekend.

**RISKS OF COUNSELING**

It is important for the client to know going into the session where the counselor stands in regard to the results from counseling. Although it is the full desire of the counselor to help the client and see true change, it must be understood that there are no guarantees for the client to get the results that they desire. During the counseling process, you may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from counseling. Our hope and desire is for true change to take place that gets to the heart of the issue resulting in long term change.

**ETHICAL GUIDELINES**

The counselor holds to a strong view of Christian ethics in and out of the counseling session. The counselor also operates under the Code of Ethics set by the American Association of Christian Counselors. A copy of the AACC code of ethics will be provided upon request.

**DISPUTES AND COMPLAINTS**

The goal of counseling is to help the client bring about true change. In order to help limit disputes, please read over the policies thoroughly. The counselor will do his/her best to ensure that the correct procedures are being followed. If there is a dispute or complaint please see the counselor in a

calm manner in order to bring about resolution. If further information is needed, please contact the Texas State Board of Examiners of Professional Counselors.

**FEES AND CHARGES**

The current fee structure is $120 per 50-minute session. Payment is due in full at each session and cash, personal checks or credit cards (MasterCard, Visa, Discover, American Express and HSA cards) are accepted. **Now accepting Blue Cross Blue Shield PPO**. Please check with your insurance company to verify what your benefits will cover prior to your first session.

****Less than a 24-hour cancellation results in a full charge for the session****

Between sessions, any phone calls longer than ten minutes result in additional fees. In the event that I am asked to appear in court or am subpoenaed on your behalf, my fee is $150 an hour for any preparation and from the time I leave the office until I am released by the court. I require an 8 hour retainer up front and ongoing appearances in court will result in additional retainer fees.

**CONSENT FOR COUNSELING SERVICES**

By signing below, I have read and understand the above informed consent. I agree to abide by the contents and am willing to participate in treatment. All members of the family who are involved in the therapy need to sign below, indicating an understanding of the policies and procedures.

Client Signature: ______________________________ Date: ____________________

Printed Name: ________________________________

Counselor Signature: ___________________________ Date: ____________________

Printed Name: Matt McKinney M.A., LPC

**If the client is under 18, I, ___________________________ (please print), have legal custody and give my consent for counseling of the below named minor.**

Client or Guardian
Signature: ______________________________ Date: ____________________

Client or Minor
Printed Name: ___________________________

# Notice of Privacy Practices
# Acknowledgment of Review

I have reviewed this office's Notice of Privacy Practices as required by HIPAA (the Health Insurance Portability and Accountability Act of 1996). The privacy practices explain how my counseling information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_________________________________________
Signature of Client or Personal Representative

_________________________________________
Date

_________________________________________
Printed Name of Client or Personal Representative

_________________________________________
Description of Personal Representative's Authority