Reset

WEST TEXAS COUNSELING & GUIDANCE

**Date**: _____

# Minor Intake Form

**The information requested on this form will be kept confidential. Please fill out the form as completely as possible.**

## Client Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date ____ __/__ __/____ Social Security Number _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____ Home phone _____

Parent/Guardian's Cell phone _____ Email _____

Who referred client? _____

Is there pending / expected court involvement: custody, placement, parental rights, CPS? ☐Y ☐ N

Is the client seeking counseling due to a court order or criminal charges? ☐ Y ☐ N

**May we:** ☐ Call ☐ Leave a message ☐ Text ☐ None **Prefer:** ☐ Cell ☐ Home

**Gender**
- ☐ Male
- ☐ Female
- ☐ Non-binary/3rd gender
- ☐ Prefer to self-describe
- ☐ Prefer not to say

**Sexual Orientation**
- ☐ Straight/Heterosexual
- ☐ Gay, Lesbian, or Queer
- ☐ Bisexual
- ☐ Prefer to self-describe
- ☐ Prefer not to say

**Do you identify as transgender?**
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

**Preferred Pronouns:** ☐She/Her/Hers ☐ He/Him/His ☐ They/Them/ Their ☐ Other _____

**Racial/Ethnic identity:** ☐ African American ☐ Asian American ☐ Native American ☐ Pacific Islander ☐ White/Caucasian ☐ Other _____

**Are you Hispanic/Latino** ☐ Yes ☐ No

**Emergency Contact:** Name _____ Contact number _____

Relationship to the client _____

**Household Income: Household Income:** ☐ 0-,9999 ☐ 10,000-19,999 ☐ 20,000-29,999 ☐ 30,000-39,999 ☐ 40,000-49,999 ☐50,000-59,999 ☐ 60,000- 69,999 ☐ 70,000-79,999 ☐80,000-89,999 ☐ 90,000-100,000 ☐ 100,000+ ☐Refused

**Education:** Current grade _____ School _____ Problems at school? ☐ Y ☐ N

If yes, please explain _____

What services does child receive from school? _____

**Religion/Denominational preference** _____ Congregation (if any) _____

**Insurance Information**

Primary Insurance Name: _____ Secondary Insurance Name: _____

Phone Number of Insurance: _____ Phone number of Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____

Insurance ID: _____ Insurance ID: _____

Insurance Group Number: _____ Insurance Group Number: _____

**Family Information:**

Parents: ☐Married ☐ Cohabitating ☐Never Married ☐Separated ☐ Divorced

Mother _____ Full Custody ☐ Joint Custody ☐ No Rights ☐Other

Father _____ Full Custody ☐ Joint Custody ☐ No Rights ☐Other

If other, please explain: _____

Is there a legal document outlining custody? ☐Y ☐ N (**copy required prior to client being seen**)

Is the minor in the care of a guardian or conservator? ☐Y ☐ N If yes, who? _____

What is this person's relationship to the child? _____

Is there a legal document detailing this? ☐Y ☐ N (**copy required prior to client being seen**)

Siblings: How many? _____ I am the: ☐Oldest ☐In the Middle ☐Youngest ☐Only Child

Sibling Ages _____

List everyone living in the home with the client (name &relationship) _____

Has the client or anyone in the client's family experienced abuse or neglect? ☐ ☐Y N

Is the client currently experiencing abuse or neglect? ☐ ☐Y N

**Check all that the client is experiencing**

| | | |
|---|---|---|
| ☐ ADHD | ☐ Guilt feelings | ☐ Problems with concentration |
| ☐ Anger | ☐ Hallucinations | ☐ Problems with memory |
| ☐ Anxiety | ☐ Irrational fears | ☐ Problems with sleep |
| ☐ Avoid open spaces | ☐ Irritability | ☐ Rage |
| ☐ Behavioral problems | ☐ Isolating/withdrawn | ☐ Relationship to children |
| ☐ Change in appetite | ☐ Lack of activities | ☐ Relationship to parents |
| ☐ Chronic fear | ☐ Loneliness | ☐ Relationship to significant other |
| ☐ Compulsions | ☐ Loss of faith in God | ☐ Religious doubts |
| ☐ Conflicts at work | ☐ Loss of hope | ☐ Restlessness |
| ☐ Decreased energy/fatigue | ☐ Loss of meaning in life | ☐ Self-injury |
| ☐ Decreased pleasure | ☐ Muscle tension | ☐ Sexual orientation |
| ☐ Delusions | ☐ Obsessions | ☐ Sexual problems |
| ☐ Depression | ☐ Other/Explain below | ☐ Significant weight change |
| ☐ Easily distracted | ☐ Panic Attacks | ☐ Stress |
| ☐ Excessive worry | ☐ Phobias | ☐ Substance use problems |
| ☐ Feel like I'm losing control | ☐ Plans to harm self | ☐ Thoughts of death |
| ☐ Feelings of worthlessness | ☐ Plans to harming others | ☐ Thoughts of harming others |
| ☐ Gender identity issues | ☐ Problems due to abuse/trauma | ☐ Thoughts of suicide |
| ☐ Grief | ☐ Problems in school | |

**Mental Health**

Has the client experienced mental health problems before? ☐Y ☐ N If yes, explain_____

Does the client have a family history of mental health problems? ☐ ☐Y N

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

☐ ☐YN If yes, when andwhere?_____

Has the client ever been hospitalized or received inpatient treatment for mentalhealth issues? ☐ Y ☐ N If yes, when and where?_____

**Substance Use History**

Does the client drink alcohol? ☐ ☐Y N On average, how many drinks do you have?_____ per_____
*quantity & type* *day/week/month*

Does the client use drugs (illegal drugs, recreational drugs, drugs not prescribed to client or used in excess of how they are prescribed)? ☐ ☐Y N If yes, whichones?_____

How often? _____ per_____ IV drug use? ☐ Y ☐ N
*quantity & drug* *day/week/month*

Has the client ever been treated (counseling, therapy, psychiatrist, medication) for a drug or alcohol problem?

☐ Y ☐ N If yes, when and where? _____

Completed successfully? ☐ ☐Y N

Has the client ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

☐Y ☐ N If yes, when and where? _____

_____ Completed successfully? ☐ Y ☐ N

**Medical History of Client**

Pediatrician _____

List any physical illness or symptoms the client is having at this time _____

List major surgeries or illnesses _____

List current medications (include dosages and physician prescribing) _____

ⓘ **Custody or guardianship paperwork is required (if applicable) prior to a minor client being seen for services.**

## Telehealth/TeleCounseling

**Telehealth/Telecounseling refers to diagnosis, consultation, billing, client education, and professional education/training delivered via electronic technology. This allows clinicians at West Texas Counseling & Guidance to connect with clients using interactive video/audio data communication. One benefit is that the client and clinician can engage in services without physically being in the same location. This can be beneficial if the client moves to a different location or is unable to meet in person for appointments. It can also serve as an opportunity for treatment that may not be accessible for the client in their location.**

**Some of the WTCG therapists practice both face to face and telecounseling means for appointments, please visit with the receptionists to determine if these options are available to you. On occasion, appointments may be switched between the two types of sessions if appropriate and both parties have the capacity.**

### *Crisis Management Plan:*

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individuals for additional assistance:

1) Personal Contact: _____

   Phone Number(s): _____

2) Personal Contact: _____

   Phone Number(s): _____

3) Professional Contact: _____

   Phone Number(s): _____

I understand if deemed necessary, my therapist may request a Welfare Check to be completed, contact local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with WTCG staff.

**Acknowledgement of these forms**

The information written on this packet is accurate, to the best of my knowledge.

_____ _____

Signature of Parent / Guardian / Client Date

WEST TEXAS COUNSELING & GUIDANCE

## *No Shows, Cancellations, & Payment for Services*

Client Name: _____

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message with our answering service is fine, even on weekends. The time you called will be posted with the message. If you do not give 24 hours' notice before cancelling your appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to schedule with another therapist or moved to the WTCG wait list for services. Clients may also be charged a **$50 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than $50 per session, the fee will be your usual session charge. Those seen without a session fee will be charged $5 per missed session.
Clients with certain insurances cannot be billed the missed appointment fee - Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

Certain insurances may not reimburse for some services offered at WTCG; in the event that insurance does not reimburse for a service provided and the client does not qualify for one of several client assistance programs at WTCG, the client will be held responsible for payment for that service.

Counselor Discretion: The counselor may choose to continue to see the client without requiring same- day appointments. The counselor may also waive the $50 fee.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation. Due to the counselors maintaining a set schedule:

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

Court appearance: In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for the costs involved in producing the records and the therapist's normal **hourly rate of $120.00** for giving that testimony. If a clinician is required to travel to a court location out of town, per diem and mileage are additional costs that you will be responsible for. Such payments are to be made prior to the time the services are rendered by the therapist.

*By signing this agreement, I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.*

_____ _____
Signature of Parent / Guardian / Client Date

_____ _____
Signature of WTCG Staff Date

***Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices***

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction. I am making an informed decision, free of any coercion, to engage in psychotherapeutic/ counseling/clinical social work services, and for purpose of research to have my non identifiable information used. If I would like to withdraw my non-identifiable information from data collection and evaluation, I must submit this request in writing to reception@wtcg.us. I understand that I will not be denied services based on my withdrawal from data collection.

If deemed necessary or appropriate to participate in telecounseling services at West Texas Counseling & Guidance, I agree to the Informed Consent for Telehealth/Telecounseling provided in the Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices**.** I have the opportunity to discuss the telehealth policies with my therapist and ask any questions I may have in regard to telecounseling services prior to participation.

_____ _____

Signature of Parent / Guardian / Client Date

_____ _____

Signature of WTCG Staff Date

## ***For Clients over the age of 12 years***
## *Patient Health Questionnaire- 9 (PHQ-9)*

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

| (Circle your answer) | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** _____ *0* + _____ + _____ + _____

**=Total Score:** _____

**If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

## ***For Clients over the age of 12 years***

## General Anxiety Disorder (GAD-7)

NAME _____ DATE _____

| 1. Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| • Feeling nervous, anxious, or on edge | ☐0 | ☐1 | ☐2 | ☐3 |
| • Not being able to stop or control worrying | ☐0 | ☐1 | ☐2 | ☐3 |
| • Worrying too much about different things | ☐0 | ☐1 | ☐2 | ☐3 |
| • Trouble relaxing | ☐0 | ☐1 | ☐2 | ☐3 |
| • Being so restless that it's hard to sit still | ☐0 | ☐1 | ☐2 | ☐3 |
| • Becoming easily annoyed or Irritable | ☐0 | ☐1 | ☐2 | ☐3 |
| • Feeling afraid as if something awful might happen | ☐0 | ☐1 | ☐2 | ☐3 |
| *Add the score for each column* | | | | |
| TOTAL SCORE *(add your column scores)* | | | | |
| | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
| 2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | ☐0 | ☐1 | ☐2 | ☐3 |

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

# PCL-5 with Criterion A

**Instructions:** This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

***Briefly identify the worst event (if you feel comfortable doing so):***

**How long ago did it happen?**_____ (please estimate if you are not sure)

***Did it involve actual or threatened death, serious injury, or sexual violence?***

_____ Yes

_____ No

***How did you experience it?***

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

***If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?***

_____ Accident or violence

_____ Natural causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

| In the past month, how much were you bothered by: | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | 0 | 1 | 2 | 3 | 4 |
| 8. Trouble remembering important parts of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me,no one can be trusted, the world is completely dangerous)? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjoy? | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | 0 | 1 | 2 | 3 | 4 |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16.Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being “superalert” or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

# C-SSRS Self-Report – Recent

| Please place a check mark in the box for the appropriate answers | In the past Month | |
|---|---|---|
| **Please answer questions 1 and 2** | **YES** | **NO** |
| **1) Have you wished you were dead or wished you could go to sleep and not wake up?** | ___ | ___ |
| **2) Have you actually had any thoughts of killing yourself?**<br>**If <u>YES</u>, answer all questions 3, 4, 5, and 6.**<br>**If <u>NO</u>, skip directly to question 6.** | ___ | ___ |
| **3) Have you thought about how you might do this?**<br>*(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")* | ___ | ___ |
| **4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them?**<br>*(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")* | ___ | ___ |
| **5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan?**<br>*(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")* | ___ | ___ |
| **6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?**<br>*(For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)* | ___ | ___ |
| **If YES, did this occur in the past 3 months?** | ___ | ___ |

WEST TEXAS
COUNSELING & GUIDANCE
VETERAN SERVICES

**Date**:_____

**Military Program Eligibility Form**

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's First Name_____ Last Name_____

1. Has the client ever served in theU.S. Military? ☐ ☐Y N

What is your current military status?

☐ Active Duty
☐ Prior Service
☐ National Guard/Reserves

2. Is the client related to any of the following who have ever served/or are currently in the U.S. military? ☐ ☐Y N

☐ Spouse
☐ Parent

**If you answered no to questions 1 or 2, you do not have to continue this form.**

3. Please fill out the below for yourself the veteran sponsor's information:

a. Dates of service: from _____to _____

b. Service Connected Disability ☐ ☐Y N

c. Rank ☐ Enlisted ☐ Officer ☐ Warrant Officer

d. Branch ☐ Navy ☐ Marine ☐ Army ☐ Coast Guard ☐ Air Force ☐ Space Force

**Eligibility of military or dependent status established by following documentation**
Individuals requesting services and claiming eligibility must provide documentation before they will be seen under a grant. Please see the example of documents below needed to verify eligibility. If an individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding.

Veterans

- ☐ DD Form 214, Certificate of Release or Discharge from Active Duty
- ☐ NGB-22, National Guard Report of Separation and Record of Service
- ☐ NA Form 13038, Certification of Military Service
- ☐ Department of Veterans Affairs (VA) official letter or disability letter
- ☐ E-Benefits summary letter
- ☐ Uniform Services Identification Card
- ☐ State of Texas Issued Driver License with Veteran designation
- ☐ Certificate verifying Active Duty Status from Department of Defense Manpower Data Center (ONLY –currently serving active duty)

Family Member

- ☐ Uniform Services Identification Card
- ☐ Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Birth Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Adoption Certificate - Must have one of the above with sponsors' proof of Veteran Status

Surviving Spouse

- ☐ Uniform Services Identification Card
- ☐ Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Death Certificate - Must have one of the above with sponsors' proof of Veteran Status

**Copy of eligibility documents provided and included in chart**
**Alert has been created in chart stating "needs military documentation".**

**Staff Member**_____ **Date** _____