Heather Isle, MA, LPC
heatherisle@gmail.com
www.heatherisle.com

6600 LBJ Frwy #240
Dallas, TX 75240
(214)282-5504

Client Information

Date: _____

Person completing this form: _____ Relationship to Minor: _____

Minor/Child's Name: _____ Age: _____ Gender: _____

Date of Birth: _____ Address: _____

City & State : _____ Zip: _____

Email address (if applicable): _____

Cell Phone: _____ Home Phone: _____

Preferred method of contact: Email Cell Work May I leave a message? Yes No

School: _____ Grade:_____

Teacher: _____ Phone: _____

If we think it is appropriate, may we contact your child's teacher to discuss your child's case? Yes No

School Counselor: _____ Phone: _____

If we think it is appropriate, may we contact your child's school counselor to discuss your Child's case? Yes No

Does your child enjoy school? Yes No

Is there anything stressful about his/her current school situation? Yes No

Parents' Information:

Parent 1's Name: _____

Parent 1's Address: _____ City: _____ State: ____ Zip: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Email Address: _____ Occupation: _____

Parent 2's Name: _____

Parent 2's Address: _____ City: _____ State: ____ Zip: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Email Address: _____ Occupation: _____

Parents' Relationship:

Never Married: _____ Divorced: _____ Separated: _____ Other:_____

List everyone who currently lives at home:_____

_____

Describe any current housing conditions or living arrangements that might be

considered challenging or unique: _____

Excluding the parents named above, what are the names and relationships of all persons (adults and children) who are significant in your child's life: _____

_____

What does your child claim as their cultural or ethnic identity? _____

What is your child's religious orientation (if any)? _____

Emergency Contact

Name: _____ Home phone: _____

Cell Phone: _____ Work phone: _____

Relationship: _____ Permission to Contact in Emergency: Yes No

Please List Any Other Medical Professionals Your Child is Currently Seeing:

_____

Referral Source: _____ May I contact them to say thank you? Yes No

Presenting Information

What are the main problems that caused your child to seek help?

_____

_____

_____

When did these problems first begin?

_____

Please check the statement below that best describes the course of these problems since they began:

___ **The problems have stayed about the same since they started.**
___ **The problems have steadily worsened since they started.**
___ **The problems seem to come and go. By the time your child seems back to their usual self, the problems usually come back.**
___ **The problems have ups and downs but haven't gone away completely since they started.**

Has there been a time in the past when your child has had similar problems? If so, when?

_____

_____

Below are listed several areas of functioning. Please check any which have been worsened due to your child's current problems.

___ **School and/or job performance**
___ **Relationship with family**
___ **Ability to manage usual chores at home**
___ **Interest in keeping up appearance**
___ **Ability to control temper**
___ **Ability to control behavior (acting before thinking)**
___ **Ability to carry out usual leisure interests and hobbies**
___ **Ability to plan for the future and set goals**
___ **Ability to carry out social life, activities, organizations, etc.**

Any other way your child's functioning has been effected: _____

_____

<u>Friendships:</u>

Does your child make friendships easily? Yes No

Does your child have difficulty maintaining friendships? _____

_____

What's your child's comfort level in social situations? _____

_____

How many close or "best friends" does your child have? _____

Briefly list what you think are your child's personal strengths and weaknesses (personality, character, intellect, skills, talents, achievements, etc.): _____

_____

What hobbies or special interests does your child currently have?_____

_____

Please list any learning disabilities: _____

Females only:

Age at first period _____ Are the periods regular? Yes No

If no, please explain: _____

_____

Do the periods affect your child's mood? Yes No

Psychological History

Has your child been to counseling before? Yes No If yes, please explain: _____

_____

Has your child had psychological testing in the past? Yes No If yes, date of testing: _____

Name and organization: _____ **Can you provide a copy of results? Yes No**

Has your child ever attempted suicide? Yes No If yes, when and what type of treatment(s) did they experience:_____

_____

Has your child ever been hospitalized for a mood disorder, eating disorder, chemical dependency, etc.? Yes No If yes, describe: _____

_____

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) who have any history of any mood disorders (depression, bipolar, anxiety), schizophrenia, drug/alcohol abuse, suicide and medications they took, if any: _____

_____

_____

Past Psychiatric Medications - Please list any medications that your child previously took on a regular basis but are not taking now.

Medication	Dose (mg)	Times/day	When started (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Medical History/Information

Child's Primary Physician's Name: _____ Phone: _____

If I think it is appropriate, may I contact the physician to discuss your child's case? Yes No

Has your family doctor or other doctor prescribed antidepressants or sedatives for your child currently or in the past? Yes No If yes, what medication(s)? _____

_____

Child's Psychiatrist Name: _____ Phone: _____

If I think it is appropriate, may I contact your psychiatrist to discuss your child's case? Yes No

Current Medications – Please list any medications your child is currently taking:

Medication	Dose (mg)	Times/day	When started (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Please list all your child's current illnesses or disabilities (e.g., allergies, ulcers, back problems, skin disorders, etc.): _____

_____

Is there anything I have forgotten to ask that you think is important for me to know about your child?

_____

_____

IF THE CHILD'S PARENTS ARE UNMARRIED, DIVORCED OR DIVORCING, PLEASE ATTACH COPIES OF ALL CURRENTLY APPLICABLE CHILD CUSTODY/CONSERVATORSHIP AND VISITATION AGREEMENTS AND COURT ORDERS AS WELL AS ANY DIVORCE DECREE.

_____ _____
Parent 1 Signature **Date**

_____ _____
Parent 2 Signature **Date**

_____ _____
Therapist Signature **Date**

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Informed Consent

Welcome. In an effort to help you make informed decisions about your therapy, I would like to explain my method of treatment, what to expect from therapy, and your rights and responsibilities as a client.

Method of Treatment:

My approach to counseling comes mostly from the cognitive-behavioral paradigm. Cognitive-behavioral counseling focuses on how our thoughts affect our emotions and behaviors, and how by being aware and changing our thoughts we can in turn change our behavior. I also believe that humans and situations are complex therefore integrating methods and techniques from other theories is helpful.

Goals, Risks and Benefits:

There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often therapy brings up painful emotions. Our goal is to confront issues and emotions together, and with time, to work through them. Other types of therapy such as support groups or therapy groups, may also be appropriate for your situation.

Length of Treatment:

Length of treatment is very difficult to predict. Each individual has unique strengths and weaknesses, and each problem is different from the next. It is my goal that each client will finish therapy in a timely manner, without unnecessary waste of time or money. That being said, some clients are in therapy for a few weeks, others a few months, and others a few years.

Fees:

Our sessions will be 50 minutes long. Together, we will decide how often we should meet. Each session will cost $125.00. In many cases, insurance will reimburse you for all or part of this fee. I do not file insurance claims for you. You must do this on your own. However, I will provide the appropriate documentation for you to give to your insurance company. I ask that you pay in full at the end of each session. You will be billed for missed sessions unless you call 24 hours in advance to cancel the appointment. Exceptions will be made, of course, in emergency situations.

Our Relationship:

Although you will be sharing personal things during the course of therapy, the tie between us is professional rather than personal. It is important to keep this relationship clear, so spending time with you socially or accepting phone calls from you at my home are inappropriate. Sexual intimacy between a therapist and a client is always inappropriate and illegal. If this has happened to you in the past, you should file a complaint with the appropriate licensing agency.

Your Right to Privacy:

I will not share the things you tell me without written permission from you. However, I can be forced to reveal our communication if:

- **I suspect child or elder abuse**
- **I feel that there is a threat that you will harm yourself or others**
- **You become unable to take care of yourself and additional help is needed**
- **There is a licensure board inquiry**
- **Legal matters are involved**

It is important in the field of psychotherapy to consult with other professionals about difficult cases. Therefore, it is possible that I will discuss your case with other therapists for the purpose of gaining information or insight about your situation. If this occurs, your name will not be revealed during these discussions. Your insurance company may contact me about the progress of treatment. This release form allows me to discuss your case with them. I will respect your privacy within these limitations.

Emergencies:

In the event of a genuine emergency, you can contact me at 214.282.5504. If for some reason you cannot reach me, call 911, 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. If I am available, I am happy to talk with you by phone; however, I may charge my regular session rate for phone calls which exceed ten minutes.

Consent To Treatment:

I, voluntarily, agree to receive mental health assessment, care, treatment, or services and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time. By signing this informed consent form, I, the undersigned client acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Therapist Signature **Date**

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Guarantee of Payment

I, _____, hereby authorize Heather Isle to charge the credit card listed below for any balance on my account.

Credit Card	Credit Card Number	Security Code	Exp. Date

Name as it appears on card

Billing Address (please include zip code)

Parent/Guardian Signature **Date**

Therapist Signature **Date**