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

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

Client Information

Date: _____

Name: _____ Age: _____ Gender: _____

Date of Birth: _____ Address: _____

City & State : _____ Zip: _____

Email address: _____

Cell Phone: _____ Work Phone: _____

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

Occupation: _____ Employed: Yes N Employer:_____

Address: _____

City & State : _____ Zip: _____

What do you claim as your cultural or ethnic identity? _____

What was your religious orientation as a child (if any)? _____

What is your religious orientation as an adult (if any)? _____

Name of Spouse or next of kin: _____

Address (if different from above): _____

City & State : _____ Zip: _____

Cell Phone: _____ Work Phone _____

Emergency Contact

Name: _____ Home phone: _____

Cell Phone: _____ Work phone: _____

Relationship: _____ Permission to Contact in Emergency: Yes No

Please List Any Other Medical Professionals You Are Currently Seeing:

_____

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

Presenting Information

What are the main problems that caused you 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 I feel almost back to my 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 you have had similar problems? If so, when?

_____

_____

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

___ **My job performance**
___ **My relationship with my spouse or significant other**
___ **My relationship with my family**
___ **My ability to manage my usual chores at home**
___ **My interest in keeping up my appearance**
___ **My ability to be the kind of parent that I want to be**
___ **My ability to control my temper**
___ **My ability to control my behavior (acting before I think)**
___ **My ability to carry out my usual leisure interests and hobbies**
___ **My ability to plan for my future and set goals for myself**
___ **My ability to carry out my usual social life, activities, organizations, etc.**

Any other way your functioning has been effected: _____

_____

Friendships:

Do you make friendships easily? Yes No

Do you have difficulty maintaining friendships? _____

_____

What's your comfort level in social situations? _____

_____

How many close or "best friends" do you have? _____

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

_____

What hobbies or special interests do you currently have?_____

_____

Please list any learning disabilities: _____

<u>Women only:</u>

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

If no, please explain: _____

_____

Do your periods affect your mood? Yes No

<u>Romantic Relationships - Are you currently:</u>

Single: _____ Married: _____ Divorced: _____ Widowed: _____ How long? _____

If married, what is your spouse's occupation? _____

Where employed? _____

Describe your relationship with your spouse or significant other:_____

_____

Have you had any prior marriages?_____ If so, how many? _____

For how long?_____ Do you have any children?_____

Names and Ages? _____

List everyone who currently lives at home:_____

_____

Describe any current housing conditions or living arrangements that might be considered challenging or unique: _____

Psychological History

Have you been to counseling before? Yes No If yes, please explain: _____

_____

Have you 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**

Have you ever attempted suicide? Yes No If yes, when and what type of treatment(s) you experienced:_____

_____

Have you 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, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide) and medications they took, if any: _____

_____

_____

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

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

Medical History/Information

Primary Physician's Name: _____ Phone: _____

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

When was your last appointment?_____ Date of last physical: _____

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

_____

Psychiatrist's Name: _____ Phone: _____

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

Current Medications – Please list any medications you are currently taking:

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

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

_____

Substance Use

Have you ever had treatment for substance use? Yes No

If yes, where and when? _____

Alcohol:

How many drinks do you have in an average week?

_____

Have you ever felt you were drinking too much?

_____

Drugs:

Have you ever used any of the following? Marijuana, cocaine, crack, amphetamine, LSD, PCP, heroin, prescription drugs, or any other substances? If yes, when was the last time. Do you feel you have a problem with any of these drugs? _____

_____

_____

Have you ever abused any prescription medications? Yes No

If so, which one(s)? _____

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

_____

_____ _____

Client 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.

_____ _____

Client 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)

_____ _____

Client Signature **Date**

_____ _____

Therapist Signature **Date**