DLR Counseling Group

COUNSELING THAT MEETS YOU WHERE YOU ARE

WWW.DLRCOUNSELINGGROUP.COM
1201 NORTH WATSON ROAD, SUITE 100-F
ARLINGTON, TEXAS 76006

PHONE/FAX 817-989-6332

INTAKE AND AGREEMENT FROM

(Form to be completed by individual and/or parent receiving services)

GENERAL INFORMATION:

Date: ______________________ Referred by: ____

Full Name: ____

Name you prefer: ________________________________ Date of Birth: ______________ Age: ________

Race: □ White □ Black □ Latino □ Asian □ Other: ______________ Gender: □ Male □ Female

CONTACT INFORMATION:

Street Address: ____ Apt. # ______________

City: ___________________________________ State: ______________ Zip Code: _________________

Home Phone: (________) ___________________ Work Phone: (________) ___________________

Mobile Phone: (_______) ___________________ Other Phone: (________) ___________________

E-mail Address: ____

How do you prefer to be contacted? □ Home □ Work □ Mobile □ E-mail

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EMERGENCY CONTACT:

Name: ____ Relationship: ____________________

Home Phone: (________) ____________________ Work Phone: (________) ____________________

Mobile Phone: (_______) ____________________ Other Phone: (________) ____________________

E-mail Address: ____

CURRENT RELATIONSHIP INFORMATION (OF PARENT IF CHILD IS UNDER 18):

Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Co-habituating

If Married, How long? _______ # of Previous Marriages for You? ___________ Your Spouse? _______

If Separated or Divorced, How long? ________________ If Widowed, How long? __________________

With Whom Do You Currently Live (Check all that apply): □ Alone □ Spouse □ Children (# _____)

□ Parents □ Sibling(s) □ Boyfriend/Girlfriend □ Other: ________________________________

CHILDREN:

*Please List **All** Your Children (Living or Deceased) as well as Children You Have Placed for Adoption*

Name	Sex	Current Age or Year of Death	Relationship to You (i.e., Natural, Step, Adopted)	Living with You?	Describe Him/Her

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FAMILY HISTORY:

Father's Name: ____ Age: ________

Race: □ White □ Black □ Latino □ Asian □ Other: ______________

Father's Mental Health History:

____

____

____

Mother's Name: ____ Age: ________

Race: □ White □ Black □ Latino □ Asian □ Other: ______________

Mother's Mental Health History:

____

____

____

If Separated or Divorced, How long? ________________ If Widowed, How long? __________________

MEDICAL HISTORY:

Primary Care Physician: __________________________________ Phone #: ______________________

Rate your current level of health: □ Very Good □ Good □ Fair □ Poor □ Very Poor

List any medical problems: ____

What prescription medications are you taking? ____

____

What over-the-counter medications do you regularly take? _______________________________

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Have you been in any type of accident (automobile or fall) in the past year? □ None

If so, please explain. ____

On average, how many hour do you sleep each night? ______________

Have you gained/lost more than 10 pounds in the past month? □ Yes □ No How much? ________

Do you suffer from chronic pain? □ Yes □ No How long has this been a problem? ____________

LEGAL HISTORY:

Do you have any pending legal charges? ______________________________________

SUBSTANCE ABUSE HISTORY:

Do you drink coffee/caffeinated drinks? □ Yes □ No How much? ________ How often? ________
Do you smoke cigarettes? □ Yes □ No How much? ________ How often? ____________
Do you drink alcohol? □ Yes □ No How much? ________ How often? ________________
Which kind(s)? ____
Do you use other drugs? □ Yes □ No How much? ________ How often? ________
Which one(s)? ____

COUNSELING HISTORY:

Are you currently seeing a psychiatrist? □ Yes □ No

Psychiatrist Name: ____________________________ Phone #: ______________

Have you ever had **individual** counseling? □ Yes □ No For how long? ______________

What were the results of the individual counseling?

____
____
____

Name and Location of Counselor: ______________ Was counseling helpful? □ Yes □ No

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Have you ever had **family** counseling? □ Yes □ No For how long? ______________________________

What were the results of the individual counseling?

____

____

____

Name and Location of Counselor: ____________________ Was counseling helpful? □ Yes □ No

Has anyone in your family ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, who and which type? ____

Has anyone in your family ever been hospitalized for any type of mental illness? □ Yes □ No

If yes, who, which hospital, and dates of stay? ______________________________________

____

Have you ever tried to harm yourself? □ Yes □ No When? _______________________________

What was your plan? ____

Have you ever tried to harm someone else? □ Yes □ No When? __________________________

What was your plan? ____

Do you have any fears about the counseling process that need to be addressed for you to get the most out

of your experience? ____

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PERSONAL HISTORY:

Highest level of education: ______________________________

Did you have any difficulty in school? If so, please explain.

Learning disability? ______________________________

Behavior problems? ______________________________

Current Occupation: ______________________________

Any Military Service: ______________________________

Current Hobbies/Activities: ______________________________

What are your strengths? ______________________________

What weaknesses do you struggle with the most? ______________________________

Do you want your counselor to incorporate faith/spiritual issues into your counseling? □ Yes □ No

Do you believe in God? □ Yes □ No Do you have a religious preference? ______________

How much influence does religion have on your daily activity? □ A lot □ Average □ A little □ None

Is there any other information you want me to know about you and your situation?______________

____

____

____

____

____

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REASONS FOR SEEKING HELP:

Please describe why you are seeking counseling **now**: ____

____

____

____

____

____

____

Where are your concerns causing the most problems for you? (please check all that apply)

□ Home □ Work □ Marriage □ Other Relationships □ God

Indicate how stressed you are by placing an "X" on the scale (1 = Very Little Stress; 10 = Extreme Stress)

____

1 2 3 4 5 6 7 8 9 10

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Please check any of the following problems that apply to you and/or your family:

Problem	You	Family	Child
Abortion	□ You	□ Family	□ Child
Aggressiveness	□ You	□ Family	□ Child
Alcohol Use	□ You	□ Family	□ Child
Anger	□ You	□ Family	□ Child
Anxiety	□ You	□ Family	□ Child
Bad Dreams	□ You	□ Family	□ Child
Career Concerns	□ You	□ Family	□ Child
Childhood Abuse	□ You	□ Family	□ Child
Children	□ You	□ Family	□ Child
Communication	□ You	□ Family	□ Child
Concentration	□ You	□ Family	□ Child
Depression	□ You	□ Family	□ Child
Disaster	□ You	□ Family	□ Child
Divorce	□ You	□ Family	□ Child
Drug Use	□ You	□ Family	□ Child
Eating Problem	□ You	□ Family	□ Child
Emotional Abuse	□ You	□ Family	□ Child
Fatigue	□ You	□ Family	□ Child
Fears	□ You	□ Family	□ Child
Finances	□ You	□ Family	□ Child
Friends	□ You	□ Family	□ Child
Gambling	□ You	□ Family	□ Child
Grief	□ You	□ Family	□ Child
Guilt	□ You	□ Family	□ Child
Hopelessness	□ You	□ Family	□ Child
Headaches	□ You	□ Family	□ Child
Health Issues	□ You	□ Family	□ Child
Legal Problems	□ You	□ Family	□ Child
Loneliness	□ You	□ Family	□ Child
Marriage	□ You	□ Family	□ Child
Memory	□ You	□ Family	□ Child
Mood Swings	□ You	□ Family	□ Child
Nervousness	□ You	□ Family	□ Child
Obsessions	□ You	□ Family	□ Child
Panic	□ You	□ Family	□ Child
Physical Abuse	□ You	□ Family	□ Child
Pregnancy	□ You	□ Family	□ Child
Recent Death	□ You	□ Family	□ Child
Recent Loss	□ You	□ Family	□ Child
Risky Behavior	□ You	□ Family	□ Child

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Self-Control	□ You	□ Family	□ Child
Self-esteem	□ You	□ Family	□ Child
Sexual Abuse	□ You	□ Family	□ Child
Sexual Problems	□ You	□ Family	□ Child
Shyness	□ You	□ Family	□ Child
Sleep Problems	□ You	□ Family	□ Child
Stress	□ You	□ Family	□ Child
Suicidal Thoughts	□ You	□ Family	□ Child
Temper	□ You	□ Family	□ Child
Trauma	□ You	□ Family	□ Child
Trouble w/job	□ You	□ Family	□ Child
Unhappiness	□ You	□ Family	□ Child
Verbal Abuse	□ You	□ Family	□ Child
Violence	□ You	□ Family	□ Child
Other: __________	□ You	□ Family	□ Child

What do you hope to gain from counseling? ____

____

____

____

____

____

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Client Agreement

Confidentiality

I understand that Texas state law requires that information provided to mental health practitioners remain confidential, and DLR Counseling Group makes every effort to insure confidentiality is maintained with respect to all aspects of your treatment. As a client, I agree to the following exceptions to confidentiality, in which case information may be disclosed to the appropriate authorities/agencies/individuals:

- **If your therapist has reason to believe that you may harm yourself or others.**
- **If your therapist has reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability.**
- **Ordered disclosure by state or federal courts.**

In addition, DLR Counseling Group requires disclosure of information in the following Circumstances:

- A signed release of information form granting permission to designated third parties to receive information.
- Discussion of the case with your therapist's clinical supervisor and/or business partner.

Appointment Attendance/Cancellation

The primary service offered is psychotherapy. The time and day of your appointment should be coordinated with your therapist.

The policy of your therapist through DLR Counseling Group is that the client agrees to the following policies:

- I understand that I am expected to attend all scheduled sessions.
- If I cannot attend a session, I agree to notify my therapist at least 24-hours in advance whenever possible (i.e. appointment at 4pm must be cancelled by 4pm and not 10pm the previous day).
- I understand that I will be charged a standard $100-150 cancellation fee for any session cancelled with less than 24-hours' notice.
- I agree to attend at least 75% of my scheduled session during any given period.
- I understand that non-adherence may result in termination or suspension of services.
- Your therapist reserves the right to transfer/terminate services at any time, for any reason they consider therapeutically appropriate.

- You will receive a letter of termination of counseling services after 90 consecutive days of not receiving services. However, if you decide to return to counseling your file will be reopened and an appointment will be scheduled.

Sessions

Sessions typically last 60 minutes. They are expected to begin promptly, and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. Your therapist is also expected to be on time, and will offer appropriate remedy if late, such as making the time up, pro-rating the fee, etc. The total number of sessions is dependent on a number of factors including your goals, time-frame, rate-of-progress, etc. **It should be noted again that psychotherapy resulting in lasting change is often a long-term process, lasting several months or longer.**

Please discuss any issues/concerns you have with your therapist so that an appropriate treatment plan can be formulated which will best suit your needs.

Fee/Payment

With regards to payment the following applies:

- Payment is due at time of service. Payment amount for therapy session and/or intake $110-$150
- **Payment will be collected in full at the start of each session**.
- If payment is not made at the start of each session, session will be suspended until payment is made.

Therapeutic Relationship

The relationship between therapist and client is the vehicle through which client change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office. Although it is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room (i.e. Facebook, Twitter, LinkedIn, etc.).

After Hours Policy/Procedures

If you need to contact your therapist at any time, you may do so by leaving a message on their voicemail. If needed, you should discuss other alternative means of contact with your therapist.
If you are in crisis, please call 911.

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DLR Counseling Group is not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs.

NOTICE: DLR Counseling Group counselors will **not** participate in any legal proceedings nor offer legal consultation.

Client Name (Please print):____

Client Signature:________________________________Date:_________________________

Client Signature:________________________________Date:_________________________

Client Signature:________________________________Date:_________________________

Therapist Signature:_____________________________Date:_________________________