



6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

**CLIENT INFORMATION FOR A MINOR**

Child (Clients) Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City & Zip: \_\_\_\_\_  
 School name: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Parent/Guardian  
 Name(s): Parent #1 (mom) \_\_\_\_\_ Parent #2 (dad) \_\_\_\_\_  
                   \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Re-married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Who will be bringing the minor to and from the sessions? \_\_\_\_\_  
 Relationship to minor: \_\_\_\_\_ Phone #: \_\_\_\_\_

(if applicable) According to the divorce decree, who is allowed to seek treatment on child's behalf?  
**\*\*\*\* Please note a copy of the divorce decree declaring guardianship MUST be on file before the child can be seen\*\*\*\***

\_\_\_\_\_ Only parent #1 (mom) \_\_\_\_\_ Only parent #2 (dad) \_\_\_\_\_ Either \_\_\_\_\_ Other

If parent #1 is re-married, step-parent name(s) \_\_\_\_\_  
 Is your home the child's primary residence? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If parent #2 is re-married, step-parent name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Where would you like me to leave you messages? \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ None  
 If there is an emergency at the office and we must cancel your appointment, where should we call?  
                   \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ None

Employer: Mom \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer: Dad \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

In the event of an emergency and we are unable to get a hold of you, whom shall we contact?

1. Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

**HEALTHCARE PROVIDER INFORMATION**

Is your child currently in counseling/mental health services elsewhere? \_\_\_\_Yes \_\_\_\_No  
 If yes, please describe? \_\_\_\_\_  
 Has your child ever received counseling or evaluation services? \_\_\_\_Yes \_\_\_\_ No  
 If yes, please describe? \_\_\_\_\_  
 How were you referred? \_\_\_\_\_  
 How did you find us? \_\_\_\_\_  
 Why are you seeking counseling for your child? \_\_\_\_\_

**WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Age: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Cash, credit cards, or checks are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. If you are using your managed care benefits (insurance), you will be responsible for all fees. You will be expected to pay for late cancelled or forgotten appointments (\$120.00) unless there has been an emergency, or at least notice of cancellation given within 24 hours. Insurance companies do not pay for missed appointment charges. This fee of \$120.00 must be paid at your next appointment or will be automatically charged to your credit card.

X \_\_\_\_\_  
 Signature of patient or parent if minor Date

**Insurance Information**

By providing the following information you are giving consent to disclose your personal health information to the insurance company identified.

Insurance Co.: \_\_\_\_\_ Member ID: \_\_\_\_\_  
 Primary Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Primary DOB: \_\_\_\_\_ Behavioral Health Deductible: \_\_\_\_\_ Deductible Met: \_\_Y \_\_N  
 Contact number for providers: \_\_\_\_\_ EAP/Pre- Authorization#: \_\_\_\_\_

## **PATIENT INFORMATION AND CONSENT TO TREATMENT**

**Welcome!** I look forward to working with you regarding the concerns that brought you here. Please read carefully the following information concerning our professional services and business policies, and discuss with your therapist any questions you may have. Your therapist will also go over this consent verbally. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

**Qualifications:** Cary Scott is a licensed professional counselor and supervisor through the state of Texas Lic.#68849, a Texas certified school counselor, certified trauma model therapist through the Ross Institute and has extensive experience in psychiatric hospital acute care treatment. Cary has facilitated group therapy for adults and adolescents in private practice and in a psychiatric facility. She has practiced as a Licensed Professional Counselor since 2011. Prior to being a mental health therapist, Cary was a high school public school teacher in the state of Texas for 12 years.

**Orientation:** Cary Scott is trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, solution-oriented, and short-term therapy. She employs a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. Our overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. Cary believes all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus she is committed to providing quality psychological care to assist you in achieving your goals.

**Nature of Psychological Services:** The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals, and working to make changes. Your therapist will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. Your therapist will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

**Therapy Relationship:** Sessions are usually 45-50 minutes on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While psychotherapy often addresses very personal issues, for your work to be therapeutic the relationship between you and your therapist must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with your therapist will be limited to sessions you schedule at our office. Your therapist will not accept friend requests on social networking sites. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. Any phone calls lasting more than 10 minutes will be charged per minute at your regular session rate. For example: if your regular session fee is \$100/per a session, a call lasting 15 minutes will be charged \$25.00.  $\$100/60 \text{ minutes} = \$1.67$ .  $15 \text{ minutes} \times \$1.67 = \$25.00$ . This same pricing structure will be used

6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

for email correspondence. For your protection, we advise emails to be limited to dealing with typical office matters such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

**Effects of Therapy:** Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However we cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, your therapist will anticipate these risks and discuss them with you throughout the course of therapy. Cary is committed to working with you to achieve the best possible results for you.

**Patient Rights:** Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. Your therapist will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with your therapist are crucial to your success in therapy. You have the right to discontinue your professional relationship with your therapist at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations your therapist makes. If your refusal compromises your therapist's ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), your therapist may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire.

Services will be rendered in a professional manner consistent with the legal and ethical standards established by the Texas state licensing board for Professional Counselors. If at any time or for any reason you are dissatisfied with our services, please let your therapist know. If you are still unsatisfied, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-252-8154.

**Referrals:** Throughout the course of therapy, your therapist may be making recommendations concerning treatment, some of which may involve alternative treatment options Cary does not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time you or your therapist believes a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

**Fees and Payment:** Cary Scott charges \$150.00/50 minute session. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. Cary requests you keep a credit card authorization form on file for billing purposes. If you wish to pay by personal check or with cash, you may do so but Cary will still need a credit card number on file to bill for no show or late cancellations. If payment becomes a hardship for you, please discuss this with Cary so a suitable payment plan can be arranged for you. Other services for which additional fees may apply include:

6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

telephone calls, clinical consultations with other providers that you give consent for your therapist to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

For legal proceedings that require your therapist's response, we bill \$400 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). Payment will be expected from you, regardless of whose attorney subpoenas my involvement. Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

**Cancellation Policy:** If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled at your regular session rate.

**Records and Confidentiality:** All records may legally be disposed of five years after the file is closed.

Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your protected health information, recorded in your patient file, which will remain confidential and stored securely. The personnel in the office who may need to access your file for administrative purposes are also bound by confidentiality. When disclosure of your records is required by law, you will be notified. Most of these provisions were described to you in the notice of privacy practices that you received with the intake packet.

**You should be aware of the following exceptions to confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others\*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

I have read the informed consent for treatment and understand the limits to confidentiality.

\_\_\_\_\_  
Client's Signature or Legal Guardian

\_\_\_\_\_  
Date



6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

### ABOUT YOUR CHILD'S EDUCATION

Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Nick Names: \_\_\_\_\_ Failure or Held Back? \_\_\_\_\_

Current School: \_\_\_\_\_

What do school personnel tell you about your child? \_\_\_\_\_

\_\_\_\_\_

Grade School	Average Grade	City	State
Pre-K			
K			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Please use the space below to share any additional information about school that you feel would be important for your therapist to know.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

### ABOUT YOUR CHILD'S FAMILY

Relatives	Name	Age/Grade	How well does child get along with this person?	Occupation
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Step Mother	_____	_____	_____	_____
Step Sister(s)	_____	_____	_____	_____
Step Brother(s)	_____	_____	_____	_____
Any other significant person? _____				
Who lives in the child's home? _____				

### ABOUT YOUR CHILD'S ROUTINE

What kinds of physical exercise does your child get? \_\_\_\_\_

How much coffee, cola, tea, or other caffeine does your child consume each day? \_\_\_\_\_

Is your child's eating restricted in any way? \_\_\_\_\_ How? \_\_\_\_\_ Why? \_\_\_\_\_

Bedtime: \_\_\_\_\_ Wake-up Time: \_\_\_\_\_ Hours of sleep on an average night \_\_\_\_\_

Does your child have any problems getting enough sleep? (Please describe fully: \_\_\_\_\_)

\_\_\_\_\_

### ABOUT YOUR CHILD'S HEALTH

Who is your child's pediatrician? \_\_\_\_\_ When was the last visit? \_\_\_\_\_

May I contact the pediatrician to discuss your child? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Any Concerns shared by the doctor? \_\_\_\_\_

If seeing a psychiatrist for medication, please give their information so I may contact them to discuss treatment goals.

Psychiatrist Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Starting with birth and proceed up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

\_\_\_\_\_

\_\_\_\_\_



6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

Describe any allergies your child has:

\_\_\_\_\_

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the counter, and others. Include dosages please \_\_\_\_\_

\_\_\_\_\_

Is there a history of mental illness in the child's family? If so, please explain:

\_\_\_\_\_

Does any family member have a current or chronic illness? If so, please explain:

\_\_\_\_\_

Is there any diagnosis of a learning disorder or impairment? Yes No I suspect but not sure I don't know

If yes or suspect, please identify or explain: \_\_\_\_\_

Anything else you are concerned about?

\_\_\_\_\_

**THESE QUESTIONS ARE REGARDING OLDER CHILDREN**

Is this child in a gang? Yes No I suspect but not sure I don't know

Has this minor ever sold drugs? Yes No I suspect but not sure I don't know

Has this child used drugs? Yes No I suspect but not sure I don't know

If so, describe which drugs, frequency, age at first use, and amounts

\_\_\_\_\_

Is the minor sexually active? Yes No I suspect but not sure I don't know

Has the minor ever contracted a sexually transmitted disease? Yes No I suspect but not sure unknown

Has this child ever been pregnant or fathered a child? Yes No I suspect but not sure unknown

If yes, please tell what happened with each pregnancy: \_\_\_\_\_

\_\_\_\_\_

Has the minor ever been a victim of physical, sexual, emotional abuse, assault, or neglect?

Yes No I suspect but not sure I don't know

If yes, please describe what happened, identify perpetrator, and age of occurrence:



### ABOUT YOUR CHILD'S SYMPTOMS

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Accident-prone                     | <input type="checkbox"/> Eating Issues                  | <input type="checkbox"/> Manipulates                          | movements   |
| <input type="checkbox"/> Affectionate                       | <input type="checkbox"/> Failure in school              | <input type="checkbox"/> Masturbation                         | <input type="checkbox"/> Runs away                      |
| <input type="checkbox"/> Aggressive                         | <input type="checkbox"/> Fantasy life                   | <input type="checkbox"/> Mental retardation                   | <input type="checkbox"/> Sad                            |
| <input type="checkbox"/> Argues                             | <input type="checkbox"/> Fearful                        | <input type="checkbox"/> Moody                                | <input type="checkbox"/> School avoiding                |
| <input type="checkbox"/> Assaults                           | <input type="checkbox"/> Feelings are easily hurt       | <input type="checkbox"/> Mute, refuses to speak               | <input type="checkbox"/> Self-harming behaviors         |
| <input type="checkbox"/> Bathroom language                  | <input type="checkbox"/> Fidgety                        | <input type="checkbox"/> Nail biting                          | <input type="checkbox"/> Sexual preoccupation           |
| <input type="checkbox"/> Bigoted                            | <input type="checkbox"/> Fighting                       | <input type="checkbox"/> Name calling                         | <input type="checkbox"/> Sexually active                |
| <input type="checkbox"/> Bossy to others                    | <input type="checkbox"/> Finger sucking                 | <input type="checkbox"/> Needs for high degree of supervision | <input type="checkbox"/> Shy                            |
| <input type="checkbox"/> Breaks rules                       | <input type="checkbox"/> Fire setting                   | <input type="checkbox"/> Negativism                           | <input type="checkbox"/> Slow-moving                    |
| <input type="checkbox"/> Breaks the law                     | <input type="checkbox"/> Friendly                       | <input type="checkbox"/> Nervous                              | <input type="checkbox"/> Slow-responding                |
| <input type="checkbox"/> Bullied by others                  | <input type="checkbox"/> Hair chewing                   | <input type="checkbox"/> New school                           | <input type="checkbox"/> Smart-alecky                   |
| <input type="checkbox"/> Bullies others                     | <input type="checkbox"/> Head banging                   | <input type="checkbox"/> Nightmares                           | <input type="checkbox"/> Smoking                        |
| <input type="checkbox"/> Cheats                             | <input type="checkbox"/> Hitting                        | <input type="checkbox"/> Noisy                                | <input type="checkbox"/> Social                         |
| <input type="checkbox"/> Clowns around                      | <input type="checkbox"/> Hostile                        | <input type="checkbox"/> Noncompliant                         | <input type="checkbox"/> Speech difficulties            |
| <input type="checkbox"/> Competition                        | <input type="checkbox"/> Hyperactive                    | <input type="checkbox"/> Obedient                             | <input type="checkbox"/> Stealing                       |
| <input type="checkbox"/> Complains                          | <input type="checkbox"/> Hypochondriac                  | <input type="checkbox"/> Obesity                              | <input type="checkbox"/> Stubborn                       |
| <input type="checkbox"/> Complains of feeling sick          | <input type="checkbox"/> Imaginary playmates            | <input type="checkbox"/> Only younger playmates               | <input type="checkbox"/> Suicide talk or attempt        |
| <input type="checkbox"/> Compliant                          | <input type="checkbox"/> Immature                       | <input type="checkbox"/> Oppositional                         | <input type="checkbox"/> Swearing                       |
| <input type="checkbox"/> Concern for others                 | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> Outgoing                             | <input type="checkbox"/> Talks back                     |
| <input type="checkbox"/> Conflicts at school                | <input type="checkbox"/> Inattentive                    | <input type="checkbox"/> Out-of-seat behaviors                | <input type="checkbox"/> Talks out                      |
| <input type="checkbox"/> Conflicts at home                  | <input type="checkbox"/> Independent                    | <input type="checkbox"/> Overactive                           | <input type="checkbox"/> Teased                         |
| <input type="checkbox"/> Conflicts with friends             | <input type="checkbox"/> Inflicts pain on others        | <input type="checkbox"/> Picks on others                      | <input type="checkbox"/> Teases others                  |
| <input type="checkbox"/> Conflicts with police              | <input type="checkbox"/> Insults others                 | <input type="checkbox"/> Poor concentration                   | <input type="checkbox"/> Temper tantrums                |
| <input type="checkbox"/> Cries easily                       | <input type="checkbox"/> Interrupts                     | <input type="checkbox"/> Pouts                                | <input type="checkbox"/> Threatens                      |
| <input type="checkbox"/> Cruel to animals                   | <input type="checkbox"/> Intimidated by others          | <input type="checkbox"/> Prejudiced                           | <input type="checkbox"/> Thumb sucking                  |
| <input type="checkbox"/> Dares others                       | <input type="checkbox"/> Intimidates others             | <input type="checkbox"/> Procrastinates                       | <input type="checkbox"/> Tics-movements or noises       |
| <input type="checkbox"/> Dawdles                            | <input type="checkbox"/> Intolerant                     | <input type="checkbox"/> Provokes others                      | <input type="checkbox"/> Timid                          |
| <input type="checkbox"/> Daydreams                          | <input type="checkbox"/> Irritability                   | <input type="checkbox"/> Rages                                | <input type="checkbox"/> Truancy                        |
| <input type="checkbox"/> Defiant                            | <input type="checkbox"/> Isolates                       | <input type="checkbox"/> Recent move                          | <input type="checkbox"/> Uncooperative                  |
| <input type="checkbox"/> Dependent                          | <input type="checkbox"/> Lacks organization             | <input type="checkbox"/> Refuses                              | <input type="checkbox"/> Uncoordinated                  |
| <input type="checkbox"/> Destructive                        | <input type="checkbox"/> Lacks respect for authority    | <input type="checkbox"/> Relationships with friends           | <input type="checkbox"/> Under-active                   |
| <input type="checkbox"/> Developmental delay's              | <input type="checkbox"/> Learning disability            | <input type="checkbox"/> Relationships with siblings          | <input type="checkbox"/> Unhappy                        |
| <input type="checkbox"/> Difficulties with parent's partner | <input type="checkbox"/> Legal difficulties             | <input type="checkbox"/> Relationships with teachers          | <input type="checkbox"/> Unprepared                     |
| <input type="checkbox"/> Disobedient                        | <input type="checkbox"/> Lethargic                      | <input type="checkbox"/> Resists                              | <input type="checkbox"/> Vandalism                      |
| <input type="checkbox"/> Disrupts family activities         | <input type="checkbox"/> Likes to be alone              | <input type="checkbox"/> Responsible                          | <input type="checkbox"/> Violent                        |
| <input type="checkbox"/> Distractible                       | <input type="checkbox"/> Loitering                      | <input type="checkbox"/> Restless                             | <input type="checkbox"/> Wastes time                    |
| <input type="checkbox"/> Dropping out of school             | <input type="checkbox"/> Loss of friends                | <input type="checkbox"/> Rocking or other repetitive          | <input type="checkbox"/> Wetting/soiling of bed/clothes |
| <input type="checkbox"/> Drug or alcohol use                | <input type="checkbox"/> Low frustration tolerance      |   | <input type="checkbox"/> Withdraws                      |
| <input type="checkbox"/> Drug sales                         | <input type="checkbox"/> Lying                          |   | <input type="checkbox"/> Work problems                  |
|   |   |   | <input type="checkbox"/> Yells                          |

6750 Hillcrest Plaza Dr. Ste. 304 Dallas, TX 75230

4037 North Goliad Ste. 115, Rockwall, TX 75087

### **MENTAL STATUS INFORMATION**

Are you or your child currently thinking about suicide or harming yourself in any way?

Yes No

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way?

Yes No

Are you or your child having any thoughts about harming anyone else in any way?

Yes No

### **STATEMENT OF UNDERSTANDING**

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

\_\_\_\_\_  
Client Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Minor

\_\_\_\_\_  
Date

### **AGREEMENT FOR THERAPY WITH A MINOR**

I, \_\_\_\_\_, the parent/legal guardian of the minor, \_\_\_\_\_,

- Give my permission for this minor to receive therapeutic services provided through Cary Scott, M.A., CSC, LPC-S.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date