Freedom Counseling
Sarah St. Cyr, M.Ed., LPC, BCBA
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Abilene, Texas 79602
(325) 676-2039x4

Professional Disclosure Statement

Qualifications and Experience: I am a Licensed Professional Counselor and a Board Certified Behavior Analyst. I have worked in the mental health field for 5 years and have received a variety of experience and training in working with mood disorders, crisis intervention, stress management, family and other issues. I have been trained in many techniques and styles for counseling intervention with individuals, groups and families. I offer services in Applied Behavior Analysis (ABA), including behavior management and skills training. I also use behavioral techniques in conjunction with traditional counseling in a variety of situations, including parent training and assistance in terminating habits or other unwanted behaviors.

Nature of Counseling: I have an eclectic approach to counseling, which means of the techniques and styles in which I have trained, I will use the approaches I feel will best serve you. I believe true and lasting help and healing comes from understanding our lives in perspective of the Kingdom of God. The foundation of my work is based on my belief in the need for a whole and meaningful relationship with Jesus Christ. I do not expect you to share my views, but do respectfully request you be open-minded as you enter counseling.

Informed Consent

Counseling Relationship: I will spend 45-50 minutes with you at each scheduled appointment. Changes will be made based on conditions and need. During this time, I hope we can establish a trusting and honest relationship to help foster your growth and health. I will do everything in my power to provide a safe and comfortable atmosphere, using all my energy to focus on you and your concerns. I ask that you come to each session prepared to work, giving yourself the best opportunity to receive help and to grow. Furthermore, I ask that discussions of personal matters be limited to our counseling sessions, when I can focus all my energy on you. Public contact, social gatherings, etc. are not an appropriate time for this. We will both be better served in saving these conversations for our counseling sessions.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. I will strive to ensure all efforts are directed towards helping you realize your desired outcome.

Costs and Reimbursements: **A fee of $135 is charged for the initial session, which usually requires a diagnostic evaluation. The fee for subsequent 45-minute hour sessions is $95. Fees are prorated based on this hourly fee. Unless previous arrangements are made, payment is expected at time of service.** Many times insurance will cover part or all of the fees. I am on the panel of many insurance providers. Please discuss your insurance or payment options and plans with me at the initial session.

Emergency Contact: On rare occasions emergency contact may be necessary. I do maintain an emergency number which is provided on an as-needed basis. Phone contact is billed at $100/hour, pro-rated on 15-minute intervals. Insurance companies do not typically reimburse for this service. Payment will be expected at the next scheduled appointment. You also have the option of calling the 24-Hour Crisis Hot Line provided by the Betty Hardwick Center at (800) 758-3344. In the case of a life-threatening crisis, please call 911 or go to the nearest Emergency Room.

Court Appearance: I can arrange to offer testimony in court proceedings. The fee for this service is $200/hour with a 5-hour minimum. If travel is required, mileage charges will be added at the rate of $1/mile plus a $50 per day per diem. Minimum payment for this service is expected at least 1 week PRIOR to the scheduled date. I cannot guarantee refunds or credits in cases of date changes due to the major scheduling conflicts involved.

Cancellations: **In order to properly serve all clients, I maintain a tight schedule. Cancelation is expected at least 24 hours in advance. Failure to cancel or missing an appointment will result in a billed No Show, which is half the standard hourly fee. Insurance will not reimburse this charge.**

Confidentiality: In order to ensure your privacy, I will not release information regarding your attendance, treatment, progress or any other aspect of your counseling without your written consent. I cannot ensure confidentiality in the waiting room, or in family or group therapy. However, I will address any matters that arise due to one of these situations. There are particular exceptions to your right of complete confidentiality: situations that give me reason to believe there is a threat to your life or the life of another; involving the physical, sexual abuse or neglect of a child; or by court order. One other exception to confidentiality is communication with your insurance provider in order to secure payment. Information on attendance, diagnosis, treatment plans, prognosis and progress are commonly requested by the insurance providers. Based on recent HIPPA legislation, you are entitled to review the information being released to your insurance provider and approve/deny its transfer. Please note that in cases where the insurance provider refuses compensation, you will be responsible for payment.

Records: All sessions become part of a clinical record. This record will not be released without your written consent. Copy cost for records is $2 per page, payable upon receipt.

By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement were answered to your satisfaction.

Client/Legal Guardian Signature	Printed Name	Date

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Client Information Form

Name: _____ Date: _____

Chief Concern

Briefly describe the main reason you are seeking therapy: _____

Referral Source

Name: _____ Relationship: _____

How did this person explain that I might be of help to you? _____

Current Employment

Employer: _____ Address: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Religious and Racial/Ethnic Identification

Current religious denomination/affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other: _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin/race or other similar way you identify yourself and consider important: _____

Primary Care Physician

Current Physician's Name: _____ Phone: _____

May I consult or coordinate treatment with your medical doctor? ❑ Yes ❑ No

Health History

1. List all significant diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, and any other medical conditions, past or current.

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List all medications (prescribed, over-the-counter, vitamins, etc.) you take or have taken in the last year.

Medication/Drug	Dose (how Much?)	Taken for?	Prescribed/Supervised by?

4. List all physicians or medical agencies treating you currently or in the last 5 years.

Name	Specialty	Address	Phone #	Date of last visit

5. List all previous mental health, psychological, psychiatric, drug or alcohol treatment, or counseling services:

When?	Provider?	For what?	What were the results?

Health Practices

1. Do you exercise? What type? How often? _____
_____

2. How much and what type of coffee, soda, tea, or other sources of caffeine do you consume each day? _____
_____

3. Do you try to restrict your eating in any way? How? Why? _____
_____

4. Do you have any problems with sleep? _____
_____

5. Are there any other medical or physical problems you are concerned about? _____
_____

For women only

1. At what age did you start to menstruate (get your period): _____

2. Menstrual period experiences:

   a. How regular are they? _____

   b. How long do they last? _____

   c. How much pain do you have? _____

   d. How heavy are your periods? _____

   e. Other experiences during periods? _____

3. Please list all of your pregnancies:

Your age	What happened with this pregnancy? Miscarriage	Abortion	Child born	Problems?

4. Menopause:

a. If your menopause has started, at what age did it start? _____

b. What signs or symptoms have you had? _____

Chemical Use

1. Do you use tobacco? ❑ No ❑ Yes If yes, how many cigarettes/cigars/other do you use each day? _____

2. How much beer, wine, or hard liquor do you consume each week, on the average? _____

3. List any other drugs you have used in the last 10 years? Amount? How often? Last Use? _____

_____

_____

_____

Education and Training

Please list all education, experience or additional training:

Dates From	To	School	Special classes?	Adjustment to school	Degree obtained?

Employment and Military Experience

Please list all employment and/or military service:

Dates From	To	Name of employer	Job title or duties	Reason for leaving

Family Relationships

1. Please list current and previous marriages or significant relationships:

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?

2. Describe your relationship with your current spouse or partner: _____

_____

3. List all children. Indicate those from a previous relationship with “P” in the last column. Indicate stepchildren with "S."

Name	Current age	Sex	School	Grade	Adjustment problems?	P/S?

4. Describe your relationship with your children: _____
_____
_____

Family History
Please describe the following:
1. Your parents’ relationship with each other: _____
_____

2. Your relationship with each parent and with any other adults (step-parents, etc.) in the past and present: _____
_____
_____

3. Your parents’ medical problems, drug or alcohol use, and mental or emotional difficulties: _____
_____

4. Your relationship with your siblings in the past and present: _____
_____
_____

Abuse History:
Have you ever been abused? ❑ No ❑Yes If yes, please indicate:

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Legal History
1. Are you planning or currently involved in a legal matter? ❑ No ❑ Yes If yes, please explain: _____
_____

2. Is this appointment required by a court, the police, or a probation/parole officer? ❑ No ❑ Yes If yes, please explain:
_____

3. List all past and present contact with the police, courts, and jails/prisons. Include all open charges and pending ones. Under "Jurisdiction,” F = Federal, S = State, Co = County, Ci = City. Under “Sentence,” write in the time and the type of sentence you served or have to serve (AR = Accelerated or Alternate Resolution, CS = Community Service, F = Fine, I = Incarceration, Pr = Probation, Pa = Parole, O = Other, R = Restitution).

Date	Charge(s)	Jurisdiction (F,S,Co,Ci)	Sentence Time and Type (AR, I, Pr, Pa)	Probation/parole officer’s name	Your attorney’s name

Checklist of Concerns

In the following list, please mark all of the items that apply to you. Feel free to add any others at the bottom under "Other concerns or issues." You may also add a note or details in the space next to the concerns checked.

- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems–too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion

❑ Threats, violence

❑ Weight and diet issues

❑ Withdrawal, isolating

❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

❑ Other concerns or issues: _____

_____

Please look back over the concerns you have checked off and list the one(s) that you most want help with.

_____

_____

Other

1. Is there anything else that is important for me to know that has not been discussed in these forms?

_____

_____

_____

_____

_____

_____

_____

_____

2. Is there anything from previous sections you would like to discuss in further detail?

_____

_____

_____

_____

_____

_____

_____

_____