Freedom Counseling
Sarah St. Cyr, M.Ed., LPC, BCBA
1219 E. South 11th, Suite A
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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Child Developmental History Record

Child's name: ________________________________ Birthdate: ____________ Age: ______
Person(s) completing this form: ________________________________ Today's date: ______________

Parents
1. Mother's name: ________________________ Birthdate: __________ Home phone: ____________
Address: ____
Currently employed: ❑ No ❑ Yes, as: ________________________ Work phone: ____________

2. Father's name: ________________________ Birthdate: __________ Home phone: ____________
Address: ____
Currently employed: ❑ No ❑ Yes, as: ________________________ Work phone: ____________

3. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other: ______________

4. Child's custodian/guardian is: ____

5. Stepparent's name: ________________________ Birthdate: __________ Home phone: ____________
Address: ____
Currently employed: ❑ No ❑ Yes, as: ________________________ Work phone: ____________

6. Other significant adult family members? ____

Development - Please fill in any information you have on the areas listed below.
1. Pregnancy and delivery
Prenatal medical illnesses and health care: ____
____

Was the child premature? ❑ No ❑ Yes
Weight and height at birth: __________ pounds __________ inches
Any birth complications or problems? ____
____

2. The first few months of life
Breast-fed? If so, for how long? Any allergies? ____

Sleep patterns or problems: ____

Personality: ____

3. Milestones:
At what age did your child do each of these?
Sat without support: ___________ Crawled: ___________ Walked without holding on: ___________

Helped when being dressed: ___________ Tied shoelaces: ___________ Buttoned buttons: ___________

Ate with a fork: ___________ Stayed dry all day: ___________ Did not soil self: ___________

Stayed dry all night: ___________

4. Speech/language development
Age when child said first word understandable to a stranger: ___________

Age when child said first sentence understandable to a stranger: ___________

Any speech, hearing, or language difficulties? ____

____

Health

1. Current Primary Care Physician's Name: ___________________________________ Phone: _______________

May I consult or coordinate treatment with your child's doctor? ❑ Yes ❑ No

2. 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

3. Describe any allergies your child has.

To what?	Reaction they have	Allergy medications

4. List all medications (prescribed, over-the-counter, vitamins, etc.) your child takes or has taken in the last year.

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

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

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

Abuse History:
Has your child ever been abused? ❑ No ❑ Yes If yes, please indicate:

Age	Kind of abuse	By whom?	Effect on child?	Whom did they tell?	Consequences of telling?

Residences
1. Homes

Dates From To	Location	With whom?	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates From To	Program name or location	Reason for placement	Problems?

Schools
List all schools attended

School (name, district, address, phone)	Grade	Age	Teacher

May I call and discuss your child with their current teacher? ❑ Yes ❑ No

Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: ______________________________

____

____

Checklist of Characteristics
In the following list, please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics." You may also add a note or details in the space next to the concerns checked.

❑ Affectionate

❑ Argues, "talks back," smart-alecky, defiant

- ❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ❑ Cheats
- ❑ Cruel to animals
- ❑ Concern for others
- ❑ Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/ friends
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's paramour/new marriage/new family
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ❑ Fire setting
- ❑ Friendly, outgoing, social
- ❑ Hypochondriac, always complains of feeling sick
- ❑ Immature, "clowns around," has only younger playmates
- ❑ Imaginary playmates, fantasy
- ❑ Independent
- ❑ Interrupts, talks out, yells
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority, insults, dares, provokes, manipulates
- ❑ Learning disability
- ❑ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ❑ Likes to be alone, withdraws, isolates
- ❑ Lying

❑ Low frustration tolerance, irritability

❑ Mental retardation

❑ Moody

❑ Mute, refuses to speak

❑ Nail biting

❑ Nervous

❑ Nightmares

❑ Need for high degree of supervision at home over play/chores/schedule

❑ Obedient

❑ Obesity

❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness

❑ Oppositional, resists, refuses, does not comply, negativism

❑ Prejudiced, bigoted, insulting, name calling, intolerant

❑ Pouts

❑ Recent move, new school, loss of friends

❑ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults

❑ Responsible

❑ Rocking or other repetitive movements

❑ Runs away

❑ Sad, unhappy

❑ Self-harming behaviors—biting or hitting self, head banging, scratching self

❑ Speech difficulties

❑ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors

❑ Shy, timid

❑ Stubborn

❑ Suicide talk or attempt

❑ Swearing, blasphemes, bathroom language, foul language

❑ Temper tantrums, rages

❑ Thumb sucking, finger sucking, hair chewing

❑ Tics—involuntary rapid movements, noises, or word productions

❑ Teased, picked on, victimized, bullied

❑ Truant, school avoiding

❑ Underactive, slow-moving or slow-responding, lethargic

❑ Uncoordinated, accident-prone

❑ Wetting or soiling the bed or clothes

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

❑ Any other characteristics: ____
____

Please look back over the concerns you have checked off and choose the one(s) that you most want your child to be helped with. It is: ____

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?

____
____
____
____
____
____
____
____

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Adolescent Information Form

Parent: This form is only necessary for children aged 13 and older. Please complete the Child Developmental History Record and have your child complete this form. In order for me to have the most accurate information, please allow your child to complete this form privately.

Adolescent: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name: ____ Nickname? ______________________________

Today's date: ______________ Your age: _________ Your phone #: ____

Your address: ____

Health

How tall are you? _______ What do you consider your ideal weight? _______

Has your weight changed more than 10 pounds in the last year? ❑ No ❑ Yes

If yes, how much? __________ Why? ____

What physical or medical problems do you have now, or have you had in the past? _____________________________

____

Family

Birth parents' names: _____________________________________ and ______________________________________

Address: ____ Phone # _________________________

Present parents'/guardians' names: _______________________________ and ________________________________

Address: ____ Phone # ________________________

How would you describe your parents' relationship? ____

What kinds of problems are you having with:

Parents/stepparents/guardians?

Parents' live-in friends or boyfriends/girlfriends?

Brothers or sisters (or stepbrothers or stepsisters)?

School

Which school do you go to? ____ Grade level/year: ________

How are your grades? ____

Problems in school? ____

Work
Do you work? ❑ No ❑ Yes If so, how many hours a week? _______ What do you do? ______________________________
Problems at work? ____

Previous counseling
1. With whom? ____ When? _________________________________
For what? ____
With what results? ____
2. With whom? ____ When? _________________________________
For what? ____
With what results? ____

Concerns
Would you like information or answers on: ❑Sex ❑Birth control ❑Alcohol ❑Drugs ❑Relationships
❑ Other concerns: ____

How important is religion to you and/or your family? ___________ If so, in what ways? ________________________________
____

What worries or upsets you?

What makes you happy?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

What would you like me to let your parents know?

What else is important for me to know?

What would you like me to ask you about?