Pat Fogle (NPI 1790752319) _____ **Carol Gindratt (NPI 1518018761)** _____
Carl McQueen (NPI 1457447823) _____ **Cynthia Young (NPI 1326142449)** _____
Sarah St. Cyr (NPI 1871852947) _____

CLIENT INTAKE FORM

(Please print clearly)

Client NAME_____ **Appt Date/Time** _____

Client DOB _____ **SSN**_____ **Email**_____

Client Phone: Home_____ **Work**_____ **Cell**_____

Client Address_____**City**_____**ZIP**_____

Parent or Legal Guardian Name_____**Phone**_____

PRIMARY INSURANCE COMPANY_____ **Phone**_____

Group or Plan #_____ **Insurance ID#**_____

Insured Name_____**DOB**_____ **SSN**_____

Relationship to Client_____ **Employer**_____

Insured Address_____

SECONDARY INSURANCE? YES NO If YES, 2nd Ins_____**ID#**_____
(CIRCLE ONE)

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO PROVIDER OF SERVICE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO GIVE MY PERMISSION FOR RELEASE OF MEDICAL RECORDS INFORMATION FOR FILING OF MY INSURANCE.

_____

CLIENT SIGNATURE (Parent or Legal Guardian if Minor) **DATE**

INSURANCE VERIFICATION FOR OFFICE USE ONLY

Date Verified: _____ _ By: _____ Spoke with: _____

Coverage: _____ Co-Pay: _____

Deductible: _____ Amount Met: _____

Pre-Certification # : _____ Visits: **90791**: **90834**: **90837:** No Limitation

Dates Covered: _____ TO: _____ **Network** **Non-Network**
Starting Ending Circle One

Family Therapy (**90847**) Covered: Yes No (Circle One)
Pre-existing Wait: Yes No (If yes, end date: _____)
Claims Mailing Address (Ask if mental health is handled by another organization):

PARENT INTAKE FORM

Child's name: _____ Nickname: _____

Date of birth: _____ Referred by: _____

I. Present Concerns:

Check any of the following behaviors that your child currently displays:

__ Cries easily
__ Wishes he/she was dead
__ Moody, sad or blue
__ Has sleeping problems
__ Underactive
__ Complains or moans
__ Seems anxious
__ Lacks interest in things he/she used to enjoy
__ Has trouble concentrating or thinking
__ Puts him/herself down a lot
__ Has eating problems
__ Spends a lot of time alone
__ Has physical complaints (e.g.., frequent Head/stomach aches, lack of energy
__ Afraid to be away from parent(s)
__ Refuses to sleep in own bed
__ Stays awake until parents return home
__ Fears horrible things will happen to self or parents
__ Clinging and demanding
__ Refuses or is very reluctant to attend school
__ Refuses or is very reluctant to play outside the home
__ Runs away from home frequently
__ Uses alcohol or illegal drugs
__ Shoplifts
__ Withdrawn at school
__ Overly shy
__ Worried and anxious no matter where he/she is
__Constantly seeks approval
__ Has one or more unusual fears
__ Very concerned with neatness, cleanliness, or predictability
__Frequently restless
__ Has trouble paying attention
__ Acts on impulse frequently
__ Has trouble sitting still
__ Has trouble following directions
__ Has learning problems
__ Disrupts the classroom
__ "Bullies" other children
__ Has a messy room
__ Frequently seems so disorganized
__ Frequently lies or steals
__ Sets fires or breaks into homes
__ Does not seem to care about others' feelings
__ Deceives and manipulates others
__ Has difficulty urinating
__ Has vaginal or penile discharge
__ Complains of irritation or pain in the genital area

__ Has been in trouble with the law
__ Is sexually promiscuous
__ Stubborn or argumentative
__ Violates minor rules at home
__ Has temper tantrums
__ Is hostile towards parents
__ Uses language in a "different" or "peculiar" manner
__ Shows little emotions
__ Gets totally absorbed in unusual activities (e.g. rocking)
__ Often hurts him/herself (e.g. head banging)
__ Seems to be in his/her own little world
__ Has very unusual thoughts
__ No interest in making friends or in being involved in activities that involve other children
__ Has coordination problems
__ Refuses to talk even though can speak and understand language
__ Frequently wets his/her pants
__ Unable to choose a career
__ Seems unsure of who he/she is and where he/she is heading in life
__ Acts more like an adult than a child
__ Frequently has bruises, burns, or cuts
__ Does not like to be home alone with certain family member
__ Goes to school early and arrives home late
__ Becomes upset when having diaper changed or being bathed
__ Doesn't respond to others
__ Doesn't like to be held
__ Insists on things remaining the same
__ Emotional reactions are inappropriate to the situation
__ Reports seeing/hearing things that others cannot
__ Needs a great deal of assistance with eating, dressing, or bathing
__ Stutters
__ Nervous habits (e.g.. pulling own hair, biting nails, thumb sucking, grimacing, eye blinking)
__ Wets the bed at night
__ Has a problem with bowel control
__ Goes back and forth between groups of friends
__ Has joined numerous groups (e.g., religious cults)
__ Seems self-conscious about his/her body

II. Medical History

A. Pregnancy
1. Planned __ Unplanned __
2. What illnesses and/or difficulties did mother have during pregnancy?

3. Length or pregnancy ____ (months)
4. Were drugs, alcohol, or medication taken during pregnancy? Explain.

5. Any previous miscarriage(s)? ____ (how many)

B. Birth
1. Length of labor ____ (hours)
2. Delivery was (check one): __ easy __normal __difficult
3. Were forceps used? ___ Was medication used? ___
4. Birth was (check one): __ emergency C-section
__ scheduled C-section
__ vaginal

5. Was the child healthy at birth? __ yes __ no
If no, explain.

6. Weight at birth: ___ pounds ___ ounces

7. Describe any difficulties from **birth to 2 years** with eating, sleeping, inconsolable crying, excessive tantrums, illness, etc.

B. Childhood Medical Information

1. Has your child had any difficulties related to eating since age 2? __ yes __ no
   If yes, explain.

2. Has your child had any sleeping difficulties since age 2? __ yes __ no

3. Check the diseases/medical conditions your child has had, indicating approximate age at the time:

__ Measles	__ Polio	__ Mumps
__ Mononucleosis	__ Chicken Pox	__ Meningitis
__ Whooping Cough	__ Hepatitis	__ Scarlet Fever
__ Encephalitis	__ Pneumonia	__ Fainting Spells
__ Asthma	__ Frequent cold sores/sore throats	
__ Frequent headaches	__ Allergies	__ Seizures
__ Tonsillitis	__ Hearing Problems	__ Vision Problems
__ Frequent ear infections	__ Diabetes	__ High fevers
__ Venereal disease	__ Rapid weight gain/loss	__ Head injuries
__ Broken bones	__ Ulcers	__ Hay fever
__ Pregnancy	__ Other:	

4. Has your child ever had to be hospitalized? __ yes __ no
   If yes, list the approximate date, age, reason, and length of time in hospital.

5. Please note below all medications your child has been on in the past month. Place an asterisk beside those medications your child is currently on. (*)

6. Please indicate approximately how long it has been since your child has had a medical check-up.

III. Developmental Information

Indicate the approximate ages that the following occurred:

_____ sat alone	_____ crawled	_____ talked in single words
_____ walked alone	_____ toilet trained	_____ talked in sentences
	_____ weaned	

IV. School and Home-Related Behaviors

1. What kinds of grades does your child currently make?

2. What grades did your child make last year?

3. Is your child currently in any resource classes? __ yes __ no
   If yes, for what subjects?

4. Does your child like school? __ yes __ no
   If not, why not?

5. Has your child ever been held back a grade? __ yes __ no
   If yes, explain.

6. Is your child currently receiving any speech therapy? __ yes __ no

7. Does your child willingly complete homework assignments? __ yes __ no

8. Have any letter, number, or word reversals been noted? __ yes __ no
   If yes, explain.

9. What, if any, learning problems have you observed in your child?

10. Name the activities or hobbies your child enjoys:

11. Describe your child's ability to make and keep friendships, and get along with peers:

V. Family Information

1. Please complete the following for those **currently living in the household:**

Name	Sex	Age	Level of Education	Occupation	Relationship (e.g. stepsister)

List any parent or sibling who **does not currently live in the household**:

_____
_____
_____
_____

2. If either parent has been previously married, please indicate approximate date of previous marriage(s), date of divorce or separation, and **the extent to which your child has contact with their parent(s) from the previous marriage.**

3. How does your child get along with members of the current household?

4. What are the current sleeping arrangements that exist for your child?

5. Describe use of alcohol, drugs, and tobacco products by your child and each family member.

6. What type of religious activities or beliefs has your child been exposed to? What are the family's beliefs about God, religion or spirituality?

7. Who is the primary disciplinarian for this child and why? _____

   What type of discipline works best?
   Swats___ Grounding___ Restriction of privileges___ Verbal reprimand___ Time out___
   Chores as punishment ___ Other: _____

   What type of rewards work best?_____

8. What type of expression of love does your child seem to want most?
   _____ Words of Affirmation
   _____ Gifts
   _____ Acts of Service
   _____ Physical Touch and Closeness
   _____ Quality Time

9. Has your child experienced any traumas in the past? Explain.

9. What significant losses (e.g., deaths, move to new town or school, loss of parent) has your child experienced in the past? Please indicate the approximate dates of these losses as well.

How would you like for counseling to help your child?

1.

2.

3.

4.

Cynthia P. Young, M.Ed.

Licensed Professional Counselor
Licensed Chemical Dependency Counselor
Certified EMDR Therapist

INFORMATION, POLICIES & PROCEDURES

WELCOME! Seeking help in dealing with life struggles is difficult for most people, so you are commended for taking on this challenge. Everyone at some point in their lifetime will need to seek help, although some do not. Whatever your situation is, there is hope.

Informed Consent: The following information is provided to make you aware of important aspects of psychotherapy with Mrs. Young, including office policies and procedures.

About Cynthia Young, LPC, LCDC: Cynthia Young has worked in private practice as a psychotherapist since 1993 with children, adolescents and adults of all ages. Her therapeutic approach is primarily cognitive behavioral, client-centered, faith-based and EMDR. Cynthia has been a member of the American Association for Christian Counselors since 1992, the EMDR International Association since 2015 and is a former member of the Association for Play Therapy.

Scheduling: The frequency and length of your sessions will be based on the issues identified and the goals you choose to accomplish. Please be aware that sometimes insurance companies restrict the frequency and length of sessions. Follow-up sessions are scheduled at the conclusion of each session. Appointments are generally scheduled Tuesday – Friday 9am- 5pm; however, that will change from time-to-time. If you have to cancel your session, please give 24hr notice via phone call, text or email. No shows and late cancellations will be charged a "No Show" fee.

Fees for Services:

Intake Evaluation (initial session):		$250
Individual Session:		$230
Family/Couple Session:		$230
No Shows:		$ 75
Therapy Reports/Letters:	30 minutes	$ 50
Legal Proceedings:	1 hour	$300

For court appearances, depositions, court preparation, phone calls and travel time (2 hr minimum).

Full payment is expected at the time of service. If you have health insurance which covers counseling, the billing personnel will file claims directly with your insurance company if you have provided all of the necessary information. Until insurance is verified, you will be responsible for the full amount each time services are rendered. Occasionally benefits

which are quoted by an insurance company over the phone may change once a claim is processed resulting in an adjustment to your co-pay amount.

Notice of Privacy Practices: Clinical records, including information provided in therapy sessions, are confidential. Exceptions to this policy include a legal or ethical responsibility to report incidents of child abuse/neglect, or serious threats to physically harm oneself or another person. In addition, records and testimony by your therapist must be released if subpoenaed and most insurance companies require a limited amount of clinical information before they will pay for services.

Electronic Communication: Please be aware that it is impossible to assure confidentiality regarding use of electronic communication such as email, texting and cell phone conversations. Your therapist will make every effort to protect all of your information; however, due to the nature of the internet and wireless communication, it is recommended that electronic communication be kept to a minimum.

Please understand that you are authorizing Cynthia P. Young, LPC, LCDC to provide counseling services to you and/or your family member(s). Cynthia Young abides by state and national ethics codes, and the ethical standards of the American Association of Christian Counselors. Violations may be reported to the Texas State Board of Examiners of Professional Counselors, Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369.

Your signature below indicates that you fully understand and will comply with the policies and procedures of this practice. If you have any questions, please feel free to discuss them with the therapist.

_____

Print client name

_____ _____

Client signature Date

_____ _____

Parent/guardian signature if client is a minor Relationship to client

Cynthia P. Young, M.Ed.
Licensed Professional Counselor
Licensed Chemical Dependency Counselor

CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION

CLIENT'S NAME_____DOB:_____

Cynthia P. Young, M.Ed., LPC, LCDC, hereby has authorization to secure and release psychological, medical, social, educational, and other clinical information regarding the client named above.

I may revoke this consent at any time by informing the above noted individual. In consideration of this consent, I hereby release the above party from any and all liability arising therefrom.

This authorization applies only to the institutions/individuals named below:

_____
_____
_____
_____
_____
_____
_____

Signature:_____Date:_____

Name of Signer (print):_____
Relationship to client:_____

Note: Photocopies of this consent form are acceptable.

1219 ES 11th St., Ste A • Abilene, Texas 79602 • (325) 676-2039