

# RESTORE HOPE COUNSELING AT FBC EASTLAND CHILD INFORMATION FORM

For counselor use only

|                                  |                               |
|----------------------------------|-------------------------------|
| Intake Date:                     |                               |
| Counselor:                       |                               |
| Fee:                             | Previous client: yes<br>or no |
| Dates of<br>previous counseling: |                               |

To assist us in helping your child, please fill out this form as fully and openly as possible. All information is held in strict confidence within legal limits. If certain questions do not apply to the child, please leave them blank.

Information supplied by: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

## IDENTIFYING INFORMATION

Child's Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Present Age \_\_\_\_\_

School Attending \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Child lives with \_\_\_\_\_

Name of Parents/Guardians \_\_\_\_\_

Address \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email: \_\_\_\_\_

May we call you at home? \_\_\_\_\_ Yes \_\_\_\_\_ No

May we call you at work? \_\_\_\_\_ Yes \_\_\_\_\_ No

May we email/write you at home? \_\_\_\_\_ Yes \_\_\_\_\_ No

Your Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Does the child attend church regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which church does the child attend? \_\_\_\_\_

What is the denomination of this church? \_\_\_\_\_

Is your child a born-again Christian? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure

### MAJOR CONCERNS

Please describe your concerns about your child and the reasons that you are seeking help. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When were these difficulties first noticed? Please explain as fully as you can. \_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List the child's behaviors that you would like to see changed. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List the child's three greatest strengths.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

List the child's three greatest weaknesses or needed areas of improvement.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Briefly describe the child's ways of expressing the following:

Anger \_\_\_\_\_

Happiness \_\_\_\_\_

Sadness \_\_\_\_\_

Anxiety \_\_\_\_\_

### BEHAVIORS OF CONCERN

Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

- |                                      |           |            |               |                |
|--------------------------------------|-----------|------------|---------------|----------------|
| 1) Hitting others                    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 2) Argues with adults                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 3) Refuses adult's requests          | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 4) Deliberately annoys people        | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 5) Blames others for own mistakes    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 6) Easily annoyed by others          | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 7) Angry/Recently                    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 8) Spiteful/Vindictive               | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 9) Defiant                           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 10) Bullies/Teases others            | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 11) Initiates fights                 | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 12) Uses a weapon                    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 13) Physically cruel to people       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 14) Physically cruel to animals      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 15) Stealing                         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 16) Forced sexual activity           | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 17) Intentional arson                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 18) Burglary                         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 19) "Cons" other people              | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 20) Runs away from home              | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 21) Truant at school                 | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 22) Doesn't pay attention to details | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 23) Several careless mistakes        | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 24) Does not listen when spoken to   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 25) Doesn't finish chores/homework   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 26) Difficulty organizing tasks      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 27) Loses things                     | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 28) Easily distracted                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 29) Forgetful in daily activities    | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 30) Fidgety/squirmy                  | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 31) Difficulty remaining seated      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 32) Runs/climbs around excessively   | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 33) Difficulty playing               | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 34) Hyperactive                      | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 35) Difficulty awaiting turn         | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 36) Interrupts others                | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 37) Problems pronouncing words       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 38) Poor grades in school            | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 39) Expelled from school             | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |
| 40) Drug abuse                       | ___ Never | ___ Rarely | ___ Sometimes | ___ Frequently |

- |                               |                                |                                 |                                    |                                     |
|-------------------------------|--------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| 41) Alcohol consumption       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 42) Depression                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 43) Shy/avoidant/withdrawn    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 44) Suicidal threats/attempts | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 45) Fatigued                  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 46) Anxious/nervous           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 47) Excessive worry           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 48) Sleep disturbance         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 49) Panic attacks             | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 50) Mood shifts               | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

For each of the behaviors noted above as occurring **FREQUENTLY**, or if it causes significant impairment, write a brief description of how it impacts the child's or other people's lives. Give examples. Use the back of this page if needed.

| Behaviors of Concern | Impact on Child or Others |
|----------------------|---------------------------|
| <hr/>                | <hr/>                     |
| <hr/>                | <hr/>                     |
| <hr/>                | <hr/>                     |
| <hr/>                | <hr/>                     |
| <hr/>                | <hr/>                     |

Has this child had any previous professional assistance with the problems stated here? If so, please provide information.

What was the name of the counselor? \_\_\_\_\_

What were the dates that the child was seen? \_\_\_\_\_

What were the results? \_\_\_\_\_

**RESTORE HOPE COUNSELING AT FBC EASTLAND  
LIMITATIONS OF CLIENT-THERAPIST  
CONFIDENTIALITY**

Confidentiality is of the utmost importance where the client-therapist relationship is concerned. We believe that it is important that the client be able to assume that their private communications with the therapist be kept private. However, there are certain exceptions which supersede the confidentiality of the client-therapist relationship. It is our ethical obligation to inform you of the exceptions.

Exceptions to Confidentiality:

1. The therapist makes an assessment of an impending suicide risk.  
(Chapter 611, Family Code)
2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person. (Chapter 261, Family Code)
3. A client acknowledges committing abuse or neglect of a child, elderly person or mentally challenged person either in present or in the past.  
(Chapter 261, Family Code)
4. There is a probability of imminent harm to the client or others.  
[Chapter 611, Sec. 004(a)(2) Health and Safety Code]
5. Counseling records may be released when they are subpoenaed by a court of law.

I have read the preceding statement and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

**RESTORE HOPE COUNSELING AT FBC EASTLAND  
CONSENT FOR COUNSELING OF MINORS**

Minor's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

This is to certify that I give permission to Restore Hope Counseling for the treatment of my child.

This counseling may include individual or group psychotherapy, counseling, and testing. This counseling may include consultations with other associates of this institution.

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent/Guardian

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone Number

**Required Custody Documentation** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

**RESTORE HOPE COUNSELING AT FBC EASTLAND  
CLIENT EMERGENCY CONTACT INFORMATION**

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

**EMERGENCY INFORMATION**

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

It is the policy of Restore Hope Counseling for a parent to remain on the premises while his/her child is in the counseling session. In the event of a medical emergency to the child and/or parent, I hereby authorize Restore Hope Counseling to notify the emergency contact.

Parent Signature \_\_\_\_\_

Parent Name \_\_\_\_\_

Date \_\_\_\_\_

## RESTORE HOPE COUNSELING AT FBC EASTLAND

405 S. Seaman St  
Eastland, TX 76448  
254-629-3355

### Informed Consent

#### Who We Are

Restore Hope Counseling is a faith-based ministry affiliated with First Baptist Church of Eastland. Restore Hope Counseling is committed to providing counseling that is based on Christian principles in a comfortable, confidential atmosphere with Christian counselors who integrate therapeutic skills with a solid biblical foundation.

Restore Hope Counseling has Master's level Counselors in order to offer a variety of counseling services. We are here to serve individuals and their families associated with FBC Eastland as well as the community at large. Services are provided by licensed and intern trained counselors. Interns are under direct supervision of other therapists or psychologists who are licensed by one or more of the following:

Texas State Board of Examiners of Psychologists 512-305-7700

Texas State Board of Examiners of Professional Counselors 512-834-6658

Texas State Board of Examiners of Marriage and Family Therapists 512-834-6657

Texas State Board of Social Worker Examiners 512-719-3521

(The above Texas State Boards receive questions and complaints regarding services by licensed professionals at the indicated numbers. Services are available to the hearing and speech impaired through Relay Texas: 1-800-735-2989.)

**Confidentiality:** Restore Hope Counseling follows the ethical standards prescribed by state and federal law, and my professional governing organizations. Discussions between social worker and clients are confidential and you have the right to a confidential relationship. The Social Worker is required by practice guidelines and standards of care to keep records of your counseling or therapy. All of our communication becomes part of yours and/or your family's clinical record. These records are confidential pursuant to certain legal and ethical limits and clinical parameters, and the HIPAA Notice of Privacy Practices provided to you. Within these limits, the information revealed by you during the course of therapy will be kept confidential. No information will be released without your written consent and authorization unless mandated by law. Possible legal exceptions to confidentiality include, but are not limited to, the following situations:

- If you reveal information that indicates you are a danger to yourself or someone else necessitating a duty to protect or duty to warn.
- If you reveal information about child abuse, neglect, elder abuse or sexual exploitation.
- If you are in therapy as the result of a court order, unless otherwise stated in the court order.
- If I receive a subpoena or a court order to disclose information.
- If you provide written permission or direction to release your record.



It is important for you to understand that all identifying information about your counseling therapy/treatment is kept confidential. Even within the church, information regarding your case is only shared with those professionals (i.e., supervisors and consultant counselors) who will confer with your service provider and thereby enhance the services you receive.

In order to protect client confidentiality, we adhere to the following procedures:

1. Written, telephone, or personal inquiries about clients will not be acknowledged without permission. You must sign a release before any information about you is given to anyone outside the counseling center. Even then we may advise you to withhold information if we feel it is in your best interest.
2. All records, tapes (if apply) or other identifying materials are kept confidential.
3. Recordings (if made) are routinely erased and records are destroyed on a regular basis as provided for in Texas law.
4. Legal limits to confidentiality are observed.

**Duty to Warn/Duty to Protect:** If Restore Hope Counseling counselors believes that I (or my child if my child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent for the Counselor to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger.

By signing this Information and Consent form, you are giving consent for me to share confidential information with all persons mandated by law or for whom you have provided written permission and you are releasing and holding me and my staff harmless for any departure from your right to confidentiality that may result.

If you have any questions or concerns regarding confidentiality, please discuss them with me before signing this form.

**Minors and Parents:** Clients under 18 years of age who are not emancipated from their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For all individuals, privacy in psychotherapy is often crucial to successful progress and there can be long-lasting negative effects if a client feels their confidentiality has been breached. It is my clinical preference, if necessary, to release summaries, with general information about the treatment goals and progress of the child's treatment and his/her attendance at scheduled sessions. If I feel that the child is in danger or is a danger to someone else, I will notify the parents and/or appropriate authorities of my concern. It is also part of my practice to work with parents, in a consulting type of role, to help them learn ways they can be most helpful to their child at home.

## **Service Policy**

Calls placed to FBC Eastland counselors will be primarily for the purpose of scheduling or rescheduling appointments. Non-emergency calls placed to the counselors will be returned within 24 hours Monday through Thursday. Calls placed Friday through Sunday will be returned by the following Monday. In emergency situation (i.e., situations where someone is out of control, has ideas or plans of self harm or of harming others, or demonstrates potentially harmful behavior) the client should dial 911 or go directly to the nearest hospital emergency room.

When a cancellation of a counseling session is unavoidable, it is important for the client to notify the counselor 24 hours in advance. *Failure to provide 24 hours notice when canceling an appointment will result in fees charged for the full session.* Consistently missed appointments (barring bona fide emergencies) or failure to complete counseling homework assignments on a regular basis may result in termination of the counseling relationship.

**Termination of Therapy:** Therapy is not mandatory unless you are in treatment as a function of a court order. Unless it is court ordered, you may choose to leave therapy at any time, but this decision is best accomplished in consultation with me. You have the right to discuss positive or negative effects of counseling with me. My goal is to provide services to you in a professional and ethical manner. If you are dissatisfied for any reason, please discuss your concerns with me.

## **Qualifications and services**

During the first few sessions, we will be working toward developing an understanding of your needs and a plan for you and/or your family. We will direct our mutual efforts toward agreed upon goals determined on an individual basis. Since therapy involves a commitment of your time, energy and finances, you should be sure that you are comfortable working with me. If you decide at any time that we are not a good fit or that other services are needed, I will provide you with appropriate referrals. For therapy to be successful it calls for an active effort on your part and will require you and/or your family to work on issues and tasks discussed during the session and also at home. While benefits are to be expected from the therapy process, specific results are not guaranteed and there are inherent risks. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes cannot be predicted. Together we will work to achieve the best results for you.

**Consent to Treatment:** By signing this Client Information and Consent Form as the Client or Guardian of the Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health treatment and services for me (or my child if my child is the client) from Restore Hope Counseling. I understand that I may stop such treatment or services at any time,

Parent Signature \_\_\_\_\_

Parent Name \_\_\_\_\_

Date \_\_\_\_\_

