2000 E. Lamar Blvd., Suite #600
Arlington, Texas 76006
Phone: 817-953-6316
Fax: 817-953-6347
E-Mail: drshae@realigncounseling.com
Web: www.realigncounseling.com

Please answer the following questions to the best of your ability. If you need additional space for answers, then please use the back of this form. If there are any questions that you prefer to discuss in person, then please feel free to leave them blank.

SOCIAL HISTORY CLIENT INFORMATION:

Name: ____Date: ___________________________

Address: ______________________________________ City: _________________Zip: ______________

E-Mail Address:____

Home Phone: _____________________________________ May we leave a message here: ❑ Yes ❑ No

Cell Phone: ______________________________________ May we leave a message here: ❑ Yes ❑ No

Work Phone: ______________________________________May we leave a message here: ❑ Yes ❑ No

Birthdate: _______________________________ Age: ______________ Sex: ❑ Male ❑ Female

Education Level: ____

Occupation: ____

Referred to this office by: ____

FAMILY HISTORY:

What kind of relationship do/did you have with your father? (select one)

___Excellent ___Good ___Fair ___Poor ___Nonexistent

What kind of relationship do/did you have with your mother? (select one)

___Excellent ___Good ___Fair ___Poor ___Nonexistent

Did anyone else have a key role in your upbringing? ❑ Yes ❑ No If yes, then who and why?
____
____

How many children are in your family of origin? ___________

Where are you in birth order (select one) ___1st ___2nd ___3rd ___4th ___5th ___6th Other________

Any step-brothers or sisters?__________ Any half-brothers or sisters?__________

Please use three or four words to describe the following: (i.e., kind, angry, etc.)

Your female parent: ____

Your male parent: ____

Your family of origin: ____

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CURRENT LIFE:

Marital Status: (select one) ___Single ___Engaged ___Married ___Separated ___Divorced ___Widowed

If married, at what age were you married? __________ Your spouse? __________

If divorced, how many times: (select one) ___1 ___2 ___3 ___4 ___5 ___6 ___7

If widowed, at what age? __________ How many years? __________

How many children do you have? __________ How many are living with you now? _______________

List names and ages: ____
____

Who else lives with you other than spouse and children?
____

Please use three or four words to describe the following: (i.e., loving, distant, etc.)

The main person in your life: ____

Your current family: ____

MENTAL / EMOTIONAL HEALTH HISTORY FAMILY HISTORY:

Are there or have there been any of the following problems in your family? (check any)

_____ Substance abuse If so, what? ____

___Suicide ___Suicide attempts ___Trauma / PTSD ___Violence ___Sexual Abuse

___ADHD ___Depression or Anger ___Anxiety or panic ___ Cutting / Self-Harm

___Bipolar Disorder ___“Nervous breakdown” ___Obsessive Compulsive Disorder

___Psychiatric Hospitalization _____ Sexual Addiction _____ Eating Disorder

PERSONAL HISTORY:

Have you personally experienced any of the following problems: (check any)

______ Substance abuse If so, what? ____

_____ Suicide _____ Suicide attempts _____ Trauma / PTSD _____ Violence _____ Sexual Abuse

_____ ADHD _____ Depression or Anger _____ Anxiety or panic _____ Cutting / Self-Harm

_____ Bipolar Disorder _____ “Nervous breakdown” _____ Obsessive Compulsive Disorder

_____ Psychiatric Hospitalization _____ Sexual Addiction _____ Eating Disorder

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Have you sought counseling before? ❑ Yes ❑ No What kind? (select one)

Pastoral___ Professional___ Both___

Have you ever attended a support or therapy group? ❑ Yes ❑ No ________________________________

Have you experienced any thoughts of harming yourself? ❑ Yes ❑ No If yes, when? ________________

Describe briefly ____

____

Did you experience any type of abuse as a child? (Physical, sexual, verbal, psychological) If so, explain

____

____

CURRENT ISSUES: (check any)

_____ Depression or anger
_____ Anxiety or panic
_____ Work issues
_____ Marital problems
_____ Violence or abuse
_____ Parenting
_____ Eating Disorder
_____ Adjustment to an event or situation
_____ Substance abuse If so, what? ____

Please give a brief description about why you are coming to therapy:

____

____

Please give a brief description about how you think the situation developed:

____

____

Please state what you hope therapy will do for you and your situation:

____

____

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Check all words or phrases that describe what you are experiencing.

☐Substance abuse/dependence/addiction
☐Depression/sad/down feelings
☐High/low energy level
☐Crying spells
☐Angry/irritable
☐Loss of interest in activities/difficulty enjoying things
☐Mood swings
☐Change in weight or appetite
☐Change in sleeping pattern
☐Self-harm/cutting/burning yourself
☐Poor concentration/difficulty focusing
☐Feelings of hopelessness/worthlessness
☐Feelings of shame or guilt
☐Feelings of inadequacy/low self-esteem
☐Withdrawing from people/isolation
☐Anxious/nervous/tense feelings
☐Panic attacks
☐Racing or scrambled thoughts
☐Flashbacks/nightmares
☐Hearing voices/seeing things not there
☐Paranoid thoughts/thoughts that someone is watching you, out to get you or hurt you
☐Thoughts of running away
☐Perfectionism
☐Rituals of counting things, washing hands, checking locks, doors, stove, etc. /overly concerned about germs
☐Binge eating/purging
☐Excessive exercise
☐Job problems
☐Other______________________________

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YOUR OBSERVATIONS: (answer briefly)

What was your childhood like?

____

____

What is your current life like?

____

____

What is your understanding of your problem?

____

____

How have you tried to solve it?

____

____

Are there any other observations that you feel might be important to note in your current life situation?

____

____

PHYSICAL HISTORY

Please rate your health: (select one)

___Excellent ___Good ___Average ___Poor

Current Medications (List any prescription medications you are currently taking . Use back if necessary)

Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Dosage	Has it been helpful?

Describe any side effects that you find troublesome from any of the medications you are currently taking.____

What other psychiatric medications have you taken in the past?______________________________
Date of last physical exam: ____________________________

Please list the name, address, and phone number of your primary care physician:

____

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List all important present or past illnesses, injuries, or handicaps:

____

Have you ever had a head injury or been hit in the head? ❑ Yes ❑ No

Did you lose consciousness? ❑ Yes ❑ No

List any current medical problems not included above:

____

In the event of a medical emergency while in our office, please contact ______________________

How related? ______________________ Phone # _____________________________.

SPIRITUAL HISTORY

Would you like your faith or spiritual preferences considered in treatment? ___Yes ____No

The above information is correct to the best of my knowledge. I understand that a written case record containing personal data, session notes, test results, and necessary psychological reports will be kept on each client. This information is privileged and will be held in strict professional confidence except in cases when the client or others are in personal danger and/or laws of agencies or civil authorities are at issue.

_______________________________________ ___________________________

Signature Date

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INFORMED CONSENT AND CANCELLATION POLICY

PHILOSOPHY: We endeavor to meet you where you are and respect your views.

COUNSELING RELATIONSHIP: Counseling session will last for approximately 50 - 60 minutes for adults and 30 - 60 minutes for minors based on attention span. The counseling contact will be limited to counseling sessions you prearrange with your counselor except in cases of crisis.

EFFECTS OF COUNSELING: Counseling is a personal exploration and may lead to major changes in your life perspective and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. We will work to achieve the best possible results for you.

CLIENT'S RIGHT: Some clients need only a few counseling sessions to achieve their goals while others require months or sometimes years of counseling. You are in complete control and may end the counseling relationship at any time, though we do ask that you participate in a termination session.

COUNSELING MINORS:

Goal: It is important that your child is able to establish a trusting relationship with the assigned staff counselor; therefore the **assigned staff will only give the parent his or her opinion about their interaction with the minor client when deemed necessary** by the assigned counselor.

- **Staff Counselor's Duty to Counselee**: The Counselee is the person whom is receiving counseling, NOT the Parent(s) and/or Legal Guardian. The Staff Counselor has no legal duty or obligation to disclose information obtained during meeting with minors unless State or Federal Laws deem otherwise.
- **Disclosure To Parent(s)/Legal Guardian**: Sometimes during a discussion with a minor, a disclosure may occur which may be necessary to share with the parent/legal guardian (i.e. drugs, pregnancy, etc.), at which time the assigned staff counselor will strongly encourage the minor to make the appropriate disclosure to the parent OR with the minors expressed consent, the assigned staff member will make the disclosure in the presence of the child when appropriate.

Parent(s)/Guardian's Duties: Also since meetings with minors often concern parental issues, the parent(s) must be willing to address those issues and make appropriate changes based on the recommendations of the counseling staff.

COUNSELING WITH LPC-INTERNS OR PRACTICUM STUDENTS: I understand that myself and/or son/daughter may be assigned to a LPC-Intern or counseling practicum student who is under the supervision of Dr. Shenan Spraberry, M.A., LPC-S or Vanessa Hamlett, M.A., LPC-S. I also understand that s/he will be discussing the case with his/her supervisor and will receive direction and instruction based on those discussions.

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FEES: ReAlign Counseling Center contracts with many insurance companies and EAP programs. Fees are based on deductibles and copays of the client's insurance company and individual policy. Dr. Shenan Spraberry does take cash payments for those without insurance. The cost is $150 per session. All interns only accept cash payments in the amount of $60 per session.

We accept cash, most major credit cards, and Flexible Spending Account debit cards.

CANCELLATION POLICY: Due to the high volume of clients seeking our services, we require that you attend all scheduled sessions unless we are notified 24-hours in advance. Emergency cancellations will be considered on a case-by-case basis. Please note that if for some reason you did not receive an automated email or text message reminder of your appointment, you are still responsible to give 24 hours notice according to the cancellation policy. If appropriate notice is not given, then you may be charged **$50 for missed or late cancellations**.

PROTECTED INFORMATION: While ReAlign Counseling Center takes reasonable precautions to ensure privacy and confidentiality, this cannot be guaranteed when using email and text messages to communicate. Please initial in the provided space if you choose to communicate with the staff counselor using the following forms of communication:

_____ Text Messages (SMS and MMS) ______ Email _______ Voicemail

APPOINTMENT CONFIRMATIONS AND REMINDERS: Automated emails and SMS text messages for appointment confirmations and reminders are a part of our calendaring system. This calendaring system is HIPAA compliant and your consent to receive these notifications is needed. Please check all that apply:

☐Appointment confirmations and reminders via email
☐ Appointment reminders via SMS text message (cell provider fees may apply)
☐ Email Surveys
☐ Email alerts for counseling center news and blogs
☐ **I do NOT wish to receive any notifications regarding any upcoming appointments.**

REFERRALS: Should you and/or your staff counselor believe that a referral is needed, some alternatives including programs and/or professionals will be provided who may be available to assist you.

Note: You will be responsible for contacting and evaluating those referrals and/or alternatives.

RECORDS AND CONFIDENTIALITY: All of our communications become part of the clinical records. Records are the property of ReAlign Counseling Center. All client records are disposed of six years after the file is closed. All of our communications are confidential with the following limitations and/or exceptions: a) it is determined you are a danger to yourself or someone else; b) you disclose abuse/neglect/exploitations of a child, elderly, or disabled person; c) you disclose inappropriate behavior by another mental heath professional; d) a court orders the disclosure of client information;

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e) you direct the counseling center to release your records to another professional; f) we are otherwise required by law to disclose information.

If your staff counselor encounters you in public, s/he will maintain your confidentiality by acknowledging you only if you approach first.

In case of emergency, we may contact:____.
Relationship: _____________________________ Telephone: ____________________________________.

FUTURE LIGITAGATION: Since it is important to maintain the confidentiality of the client(s) both now and in the future (including minors), the undersigned agrees not to involve ReAlign Counseling Center in any current or future arbitration, mediation, and/or litigation within the court system.

LEGAL NOTICE: By placing your signature below you certify and acknowledge that you have fully read and understand this Counseling Informed Consent, and agree fully to the terms and conditions stated within.

____ ____________________

Signature of client (or guardian, if minor)   Date

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section, P.O. Box 141369 Austin, Texas 78714-1369 OR call 800-942-5540 to request the appropriate form or obtain more information.
Texas LPC Board www.dshs.state.tx.us/counselor/
TX Attorney General www.texasattorneygeneral.gov/consumer/complain.shtml
Dept. of Health & Human Services http://www.hhs.gov/ocr/office

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HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This is your Health Information Privacy Notice from **ReAlign Counseling Center**. This notice describes how we protect the Personal Health Information we have about you which relates to you and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your past, present or future mental health, treatment or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act **("HIPAA")**. We are required by law to:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- Follow the terms of this notice.

We protect your Personal Health Information from inappropriate use or disclosure. Our employees are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information ONLY when there is an appropriate reason to do so.

We will not disclose your Personal Health Information to any other company for their use in marketing their products to you.

The main reasons for which we may use and may disclose your Personal Health Information are:

- **For Payment:** We may use and disclose Personal Health Information to pay for process your payment
- **For Health Care Operations:** We may also use and disclose Personal Health Information at your request for your insurance needs.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone's health or safety.
- We may use Personal Health Information to provide you with information about services that may be of interest to you.
- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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• **When Requested as a Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit, divorce or a dispute, we will release PHI at your request. Please note per your signed Informed Consent, you have agreed not to involve The Fountains Counseling Center in any current or future arbitration, mediation, and/or litigation within the court system.

• **Other Uses of Personal Health Information:** Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization. You should understand that we will not be able to take back any disclosures we have already made with authorization.

• **Cost of Processing PHI Request:** Due to the cost of preparing and transmitting requested PHI, we will charge $40 flat fee for up to 25 pages and an additional $1 per page thereafter.
In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you.

• **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. We may deny your request if you ask us to amend Personal Health Information that:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
- Is not part of the Personal Health Information kept by or for us, or
- Is not part of the Personal Health Information which you would be permitted to inspect and copy.

• **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will NOT include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel, or made pursuant to your authorization or made directly to you. You must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use of disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in you care of payment for you care, like a family member or friend. While we will consider your request, we are not required to agree to it.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that

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communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

• **Changes to This Notice:** We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future.

Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available at the reception desk in our counseling center. You may also obtain a copy of this notice at our web site.

I have read and understand my Rights to Privacy & Disclosure as outlined in this Notice.

______________________ ____
DATE SIGNATURE

____
PRINTED NAME