

**Karen Stone, MS, LMFT, LCDC**

860 Hebron Parkway, Suite 803

Lewisville, TX 75057

214-454-9672

Today's date: \_\_\_\_\_

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

Name of parent/guardian (if under 18 years):  
\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

Please list any children & their age/s: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

Street and Number

City, \_\_\_\_\_ State, \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Work Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

In case of therapist emergency what is the best way to contact you? Circle all that apply

Home      Cell      Work      Email

Referred by (if any): \_\_\_\_\_

If someone other than you is responsible for payment please fill in the following information:

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I give consent for therapist to contact above individual or organization regarding payment for services rendered.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

In case of **client** emergency who may we contact? \_\_\_\_\_  
Name

Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*\*\*\*By signing this form I give consent for therapist to contact the above person in the event of an emergency.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No  
 Yes, previous therapist/practitioner: \_\_\_\_\_

Yes, current psychiatrist: \_\_\_\_\_

Are you currently taking any prescription medication?  Yes  No

Please list: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed psychiatric medication?  Yes  No

Please list and provide dates: \_\_\_\_\_  
\_\_\_\_\_

Are you currently experiencing anxiety, panic attacks, or have any phobias?  Yes  No

If yes when did this begin? \_\_\_\_\_ Additional information: \_\_\_\_\_  
\_\_\_\_\_

Are you currently experiencing depression?  No  Yes

Are you having any difficulty with your sleeping habits?  No  Yes

Do you or does anyone in your family have a history of suicidal attempts or ideation? Or self-harm?

No  Yes If yes, please explain; \_\_\_\_\_  
\_\_\_\_\_

Have you experienced any traumatic events?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often do you engage in recreational drug (either illegal or prescription) use?

Daily  Weekly  Monthly  Infrequently  Never

How often do you drink alcohol?

Daily  Weekly  Monthly  Infrequently  Never

Have you or a family member experienced or are you currently experiencing any of the below?

- |  |  |  |
|--|--|--|
| Divorce                                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Serious illness                              | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Relocation                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Abuse (either physical, sexual or emotional) | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Grief or significant loss                    | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Unemployment                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| ADD/ADHD                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Eating Disorder                              | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Legal issues                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Psychiatric Disorder                         | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |
| Other significant event or situation         | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Self <input type="checkbox"/> Family member |

Please give additional information regarding any category you checked yes for: \_\_\_\_\_

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Any additional information you feel would be helpful for the therapist to know? \_\_\_\_\_

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Why are you seeking counseling at this time? \_\_\_\_\_

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INFORMED CONSENT STATEMENT

I am a Licensed Marriage and Family Therapist and a Licensed Chemical Dependency Counselor. I have a bachelors' degree in Rehabilitation (with an Addiction Studies minor) from University of North Texas and a Masters in Family Therapy from Texas Woman's University. These qualifications allow me to work with families, couples as well as individuals. Additionally I am trained in EMDR.

I do not provide 24-hour crisis counseling, and am not available after regular office hours. If you have an immediate mental health need please call 9-1-1 or go a hospital emergency room for assistance. If you need to get a hold of me please feel free to leave me a voice message with your name and phone number. Please know that at times I may not be able to return a call the same day, but I make every effort return the call as soon as I am able. You may also email me regarding NON-confidential information. Email is not considered a confidential format and I CANNOT guarantee confidentiality of those communications. You may also text me regarding appointments but it is NOT a confidential method so please be aware and limit texts accordingly.

The counseling process involves some risks over the course of treatment. You may experience stress or at times problems may seem to worsen before improving. Discussing unresolved problems can bring about discomfort. The risks depend on your unique situation and no specific outcomes from therapy can be guaranteed. This often happens in family or couples counseling. Please bring any concerns or issues to the sessions so we can work to bring about the best possible outcomes. Each client's goals are different so length of the counseling process will vary from client to client. While some clients reach their goals in a few sessions, it may take months or longer to achieve the desired results. You have the right to terminate therapy at any time.

A counseling session is 50 minutes in length. My rate is \$100.00 per session. I accept cash, check, and American Express, VISA, and Master Card. Payment is due at each session unless prior arrangements have been made for a third party to pay for treatment. Please understand that a signed consent form will be required if there is a third party paying for your treatment. There will be at \$25.00 processing fee if a check is returned for non-payment in addition to the session fee. Your session time is held for you, if you are unable to attend a session you will need to cancel 24 hours in advance, otherwise you will be billed a full session fee for the missed session. Exceptions may be made for emergencies.

I do not agree to serve as an expert witness or provide testimonial services for you and you agree to not cause my services to be used this way. Should you, your attorney, or your ex-spouse's attorney subpoena me or your client files or involve me in a court related process you agree to pay me \$300.00 per hour for every hour of my time which includes case preparation, travel time, time spent waiting to appear and the appearance in court. You further agree to pay a \$2000.00 retainer fee at the time a subpoena is served; all subpoenas will be turned over to an attorney at your expense.

I will make every effort to protect your confidentiality. A consent is required for the release of any information to any person, entity, organization or business. There are circumstances when disclosure can occur without your consent. The following are examples of times a consent is not needed: when you are a danger to yourself or to someone else, situations of suspected child abuse, suspected abuse of elderly adult, or an adult with mental or physical disabilities, certain legal proceedings, when records are subpoenaed or court directed, court mandated treatment.

By signing below I understand the above information. I give my consent for treatment and agree to pay all fees incurred during my treatment.

\_\_\_\_\_  
Name printed

\_\_\_\_\_  
Name signed

\_\_\_\_\_  
Parent or guardian: Name printed

\_\_\_\_\_  
Parent or guardian: Name signed

\_\_\_\_\_  
Date