Karen Stone, MS, LMFT, LCDC
860 Hebron Parkway, Suite 803
Lewisville, TX 75057
214-454-9672

Today's date:________________

Clients Names: ____

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

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

His Cell Phone:______________________________ May we leave a message? □ Yes □ No

Her Cell 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 clients:_________________

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

____
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 either of you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: ____

□ Yes, current psychiatrist:____

Are either of you currently taking any prescription medication? □ Yes □ No

Please list: ____

____

Have either of you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: ____

____

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

If yes when did this begin?___________________________ Additional information:_____________

____

Are either of you currently experiencing depression? □ No □ Yes

Are either of 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 either of 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	□ No □ Yes □ Self ____ □ Family member
Serious illness	□ No □ Yes □ Self ____ □ Family member
Relocation	□ No □ Yes □ Self ____□ Family member
Abuse (either physical, sexual or emotional)	□ No □ Yes □ Self ____ □ Family member
Grief or significant loss	□ No □ Yes □ Self ____□ Family member
Unemployment	□ No □ Yes □ Self ____ □ Family member
ADD/ADHD	□ No □ Yes □ Self ____□ Family member
Eating Disorder	□ No □ Yes □ Self ____□ Family member
Legal issues	□ No □ Yes □ Self ____ □ Family member
Psychiatric Disorder	□ No □ Yes □ Self ____□ Family member
Other significant event or situation	□ No □ Yes □ Self ____ □ Family member

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

____

____

____

____

____

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

____

____

____

Why are you seeking counseling at this time? ____

____

____

____

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 the 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 your self 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 signed	Name signed
______________________________	______________________________
Name printed	Name printed
______________________________	______________________________
Date	Date