Charissa Fry PLLC: Licensed Professional Counselor
The Vale Counseling and Therapeutic Center
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972-698-8478
www.charissafry.com
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Client Intake

Client Name: _____ Date: _____
Parent/Guardian Name(s) _____
Gender: Female ___ Male ___ Date of Birth: _____ Age: ____ SS#_____
Address: _____ City: _____ State: ___ Zip: _____
Client Phone: _____ Client Email: _____
Parent/Guardian Phone #1: _____ Email: _____
Parent/Guardian Phone #2: _____ Email: _____
Employment/School: _____ Grade level _____
Emergency Contact: _____
Household members: _____
If client is a minor and has visitation/custody at a second home:
Address: _____ City:_____ State: ___ Zip: _____
Household members: _____

In your own words, what are three goals you would like to work towards during therapy?

1. _____
2. _____
3. _____

Please indicate what major stressors and/or changes have you experienced in the past 12 months:

__ Serious Illness
__ Major family illness
__ Financial instability
__ Sleep
__ Weight
__ Social isolation
__ Emotional abuse
__ Violent behaviors
__ Death of a friend/family member
__ Relationship change
__ Obsessive/Compulsive behavior
__ Eating/Appetite
__ Concentration
__ Physical abuse
__ Suicide attempt
__ Legal problems
__ Divorce/Separation
__ School/Employment change
__ Sexual issues
__ Exercise
__ Panic attacks
__ Sexual abuse
__ Self harm
__ Suicidal thoughts
__ Other Concerns: if yes, please explain:

_____
_____
_____

Rate your strengths and protective factors:

Secure Housing	__ Present	__ Absent	__ Unknown
Secure Employment	__ Present	__ Absent	__ Unknown
Perceived Social Support	__ Present	__ Absent	__ Unknown
Perceived Family Support	__ Present	__ Absent	__ Unknown
Responsible for Others (family, close friends, etc)	__ Present	__ Absent	__ Unknown
Coping Skills	__ Present	__ Absent	__ Unknown
Faith/Spirituality	__ Present	__ Absent	__ Unknown
Insight	__ Present	__ Absent	__ Unknown
Problem Solving Abilities	__ Present	__ Absent	__ Unknown
Ability to Adapt/Change	__ Present	__ Absent	__ Unknown
Sense of Purpose or Meaning In Life	__ Present	__ Absent	__ Unknown

Additional strengths:

_____
_____
_____

Family Information

Is there a biological family history of:

__ Depression __ Suicide attempts __ Anxiety __ Eating Disorders
__ Mental Illness __ Emotional abuse __ Physical abuse __ Sexual abuse
__ Addiction __ Chronic illness: if yes, please explain_____
__ Other, please specify: _____
_____

Medical Information

Primary physician: _____ Phone: _____
Date of last exam: _____ Major or Chronic Illness/Injuries: _____
_____
Operations: _____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been prescribed medication for psychiatric or emotional problems?
__ Yes __ No If yes, please describe the following:

When	Prescribing Doctor	Prescription	Reason for Rx	Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been hospitalized for a psychiatric or emotional health reason? (inpatient/outpatient)
__ Yes __ No If yes, please describe the following:

When	Hospital	Reason	Results
_____	_____	_____	_____
_____	_____	_____	_____

Substance Use Information

Tobacco/Vaping

Do you smoke? __ Yes __ No
If no, did you smoke in the past? __ Yes __ No
If yes: How many times a day _____ Began at what age? _____
If you no longer smoke, when did you quit? _____

Alcohol

Do you consume alcohol? __ Yes __ No
If so, how much? __ 1x/month __ 3x/month __ 1x/week __ daily __ other
Check all that apply: __ beer __ wine __ hard liquor

Drugs (including marijuana)

Do you use any street drugs and/or misuse prescription drugs? __ Yes __ No
If yes, please list below:

Name of Drug	Frequency of Use
_____	_____
_____	_____

Have you ever been in a drug or alcohol treatment program? __ Yes __ No
If yes, please specify: __ Inpatient __ Outpatient
When: _____
How long: _____
Outcome: _____

Other

Is there anything else your mental health provider should know prior to beginning counseling?
_____
_____
_____

What would you like to be different in your life when therapy concludes?

_____

_____

How were you referred to counseling? _____

If client is a minor and subject to custody/visitation agreements, please provide the counselor with the most recent and official legal document indicating current custody/visitation rights and arrangements.

Please sign below indicating you have provided the most recent and official legal document concerning custody/visitation and parental rights:

Signature: _____ Date: _____

Honesty Declaration:

I, _____, attest that the answers provided throughout this client information form have been answered truthfully and completely to the best of my recall. I attest that I have not deliberately or intentionally misrepresented my medical, social or psychological history in any way with my responses.

_____ _____

Signature Date

Office Procedures and Disclosure Information

People entering counseling often feel anxious about the beginning of the process. This is partly due to the uncertainty of what will occur in session, what is expected of the client, what role the therapist will play, payment, and confidentiality. Please read the following information which was prepared to help you know what to expect. Please keep this information for future reference and feel free to ask questions concerning information at any time during the course of treatment. You must sign the Consent to Treatment on the last page before we begin treatment.

Therapy Sessions

At the end of our initial meeting we will discuss a general plan for continued therapy sessions if you or your family and I are in agreement to commit to a counseling relationship. There are no guaranteed outcomes in the process of psychotherapy. The results of your counseling experience will depend our interpersonal relationship and your motivation and efforts toward honesty, self-reflection, openness, and desire to change.

I will approach the counseling process from a Christian and Biblical worldview. However, I work with people of all faiths and encourage spirituality as an important part of the therapeutic process. As part of the counseling process you may experience challenging and painful emotions including anger, sadness, anxiety, grief and so on. These emotional responses are a natural result of the process of reducing distressing symptoms, life change, increased insight and peace in life, healthier relationships, and a deeper spiritual walk. I am available to walk through this process of change and all difficult emotions and decisions that accompany progress. You have the right to ask questions to gain information on any aspect of the counseling process. Additionally, you have the right to withdraw from treatment at any time and ask for referrals.

Confidentiality

One of the most important and unique aspects of the client/therapist relationship is confidentiality. I will not disclose any information about you or your child without your explicit request. The law also recognizes the special confidential nature of the client/therapist relationship. However, the law requires that I must release information in the following situations: 1) If I have a reason to suspect child, spousal, or elder abuse, 2) If I am aware that you become a danger to yourself or others.

Emergencies

This office does not provide 24 hours phone coverage and all after-hours phone messages will be returned the next business day (excluding Fridays when the office is closed). If you need to reach me prior to our next scheduled appointment, please call the counseling center during office hours to speak with the Administrative Assistant. I will return your call within 24 hours, Monday through Thursday. If you require emergency services, please call 911.

Fees and Insurance

Payment is required at the time of the session for the current session and all additional services provided in between appointments. We accept checks, cash, and credit cards. If you are unable to pay the fee at each session, please discuss your difficulty with the counselor.

If you choose to submit claims for psychological services to your medical insurance company, you will need to meet the criteria for an official diagnosis. This diagnosis, basic information about you including goals, progress, and treatment plans will be required by the insurance company and may become a permanent part of your medical records. The confidentiality of your information cannot be guaranteed once it is sent to the insurance company.

Cancellations

We require 48 hours notice to cancel an appointment. If you give less than 48 hours notice, you may be charged for the session. You are given one excused late cancellation per calendar year for sickness and emergencies. If you cancel within the 48 hour cancellation window, you can choose to pay the full cancellation fee or reschedule within the same week if there are openings available.

In Cases of Separation and Divorce and other Legal Matters:

You agree to provide me with legal documentation regarding conservatorship and your legal rights to consent to treatment for your child. If parents share joint managing conservatorship both must sign consent to treatment. I will provide treatment that will help facilitate your child's adjustment to the separation or divorce but I do not provide forensic interviews, or custody or visitation evaluations. I do not serve as an expert witness or provide testimonial services in custody battles. By signing this form you agree not to subpoena me to court for testimony or for disclosure of treatment records.

Email

Email is not completely secure or confidential. Any electronic transmissions of information by you are retained in the logs of your internet service provider. While it is unlikely that someone will be looking at those logs, they are, in theory, available to be read by the system administrator of the internet service provider. I cannot guarantee confidentiality over email. **Emails I receive from you and my responses will become part of your file. In the treatment of minors, the file and all emails contained in the file are accessible by any parent/guardian who request the information if the parent/guardian has the legal right to information regarding the mental health treatment of the child.**

Parents

When working with minors, the principle of confidentiality between the client (minor) and the therapist is of utmost importance and value in order to achieve therapy goals. I ask parents to respect the confidentiality between myself and your child. I will break that confidentiality 1) If your child is a danger to self or others 2) he/she is a victim of abuse 3) the child is engaging in ongoing risky behavior that might cause severe harm or death.

HOWEVER, as a parent/guardian you have the right to know the full extent of the content of all therapy sessions. You have the legal right to a physical copy of the child’s file for $100. You can request the counselor to coordinate or release information to a third party by phone for $15. You may also request updates about the child’s progress at any time.

I do not update parents after every therapy session. HOWEVER, I will immediately contact you for urgent matters regarding your child.

Parents/Guardians are required to setup a minimum of one 30-minute parent/guardian session during non-peak office hours every 4-6 weeks. The session can be in person in the counseling office or by phone or video. This regular parent/guardian session is the primary mode of communication between the counselor and the parent/guardian and is an integral and critical part of effective therapy for your child. Parents/Guardians are STRONGLY encouraged to send regular emails before each session to update the therapist on the child's life. Parent session of 30 minutes will be billed at half the 50 minute fee.

You are welcome to setup parent sessions for longer updates, parent coaching, to receive help with parenting questions and receive appropriate language for difficult subjects.

Court Testimony

I do not go to court. I am not considered an expert witness in the field of mental health. Should I be required to engage in legal proceedings, my fee is $200.00 per hour for each hour spent in preparation for testimony, and $200.00 per hour for travel time to and from court. My fee is $200.00 per hour for my time at the courthouse. Should I be called to testify or be at court to be available to testify or participate in legal proceedings in any manner, I require a minimum *prepayment* of three (3) hours of court time, or $600.00, regardless of the outcome of how my time is spent on the day of court. There will be no refunds for calling me to court and not requiring anything further of me that day. My retaining fee of $1,500 must be prepaid if any actions are required on my part to fulfill legal obligations. If you do not pay the retaining fee 10 days in advance, your refusal communicates your agreement not to involve me in legal proceedings of any kind.

Consent to Treatment

I have received a copy of the **Office Procedures and Disclosure Information**. I consent to psychological services for myself (and/or for my child).

I understand that during counseling, issues may be discussed that could be upsetting in nature but that this would be a part of the therapeutic process. I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults. I understand that state and local laws require that my therapist report all cases in which there exists a danger to others or myself. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand if I have a managed care insurance plan that offers reimbursement to The Vale Counseling and Therapeutic Center, I must indicate that at the time I complete my initial paperwork, and call my insurance company to authorize sessions to cover therapy. If I have traditional insurance, I understand it is my responsibility to file for reimbursement, The Vale Counseling and Therapeutic Center will supply a receipt that will have the necessary information needed to process the claim. I agree to pay my counseling fees as arranged at the time of my first session in a timely manner. Should a third party other than insurance agree to pay for my sessions, I agree to allow The Vale Counseling and Therapeutic Center to release billing information to the third party.

My signature below means I have read this form and the Office Procedures and Disclosures Information document below and understand and agree with the contents; I have been given opportunity to ask questions and have received answers to my questions that I understand. My signature also means I am making a voluntary, informed choice to enter a counseling/therapy relationship with Charissa Fry, MA, LPC on behalf of myself or someone under my guardianship.

_____ _____

Signature Date

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

The Holmes-Rahe Life Stress Inventory

The Social Readjustment Rating Scale

INSTRUCTIONS: *Mark down the point value of each of these life events that has happened to your during the previous year. Total these associated points.*

LIFE EVENT	MEAN VALUE
1. Death of spouse	100
2. Divorce	73
3. Marital Separation from mate	65
4. Detention in jail or other institution	63
5. Death of a close family member	63
6. Major personal injury or illness	53
7. Marriage	50
8. Being fired at work	47
9. Marital reconciliation with mate	45
10. Retirement from work	45
11. Major change in the health or behavior of a family member	44
12. Pregnancy	40
13. Sexual Difficulties	39
14. Gaining a new family member (i.e. ... birth, adoption, older adult moving in, etc.)	39
15. Major business readjustment	39
16. Major change in financial state (i.e. ... a lot worse or better off than usual)	38
17. Death of a close friend	37
18. Changing to a different line of work	36
19. Major change in the number of arguments w/spouse (i.e. ... either a lot more or a lot less than usual regarding child rearing, personal habits, etc.)	35
20. Taking on a mortgage (for home, business, etc. ...)	31
21. Foreclosure on a mortgage or loan	30
22. Major change in responsibilities at work (i.e. promotion, demotion, etc.)	29
23. Son or daughter leaving home (marriage, attending college, joined mil.)	29
24. In-law troubles	29
25. Outstanding personal achievement	28
26. Spouse beginning or ceasing work outside the home	26
27. Beginning or ceasing formal schooling	26
28. Major change in living condition (new home, remodeling, deterioration of neighborhood or home etc.)	25
29. Revision of personal habits (dress manners, associations, quitting smoking)	24
30. Troubles with the boss	23
31. Major changes in working hours or conditions	20
32. Changes in residence	20
33. Changing to a new school	20
34. Major change in usual type and/or amount of recreation	19
35. Major change in church activity (i.e. ... a lot more or less than usual)	19
36. Major change in social activities (clubs, movies, visiting, etc.)	18
37. Taking on a loan (car, tv, freezer, etc.)	17
38. Major change in sleeping habits (a lot more or a lot less than usual)	16
39. Major change in number of family get-togethers ("")	15
40. Major change in eating habits (a lot more or less food intake, or very different meal hours or surroundings)	15
41. Vacation	13
42. Major holidays	12
43. Minor violations of the law (traffic tickets, jaywalking, disturbing the peace, etc.)	11

Now, add up all the points you have to find your score **TOTAL** ____

150pts or less *means a relatively low amount of life change and a low susceptibility to stress-induced health breakdown.*
150 to 300 pts *implies about a 50% chance of a major health breakdown in the next 2 years.*
300pts or more *raises the odds to about 80%, according to the Holmes-Rahe statistical prediction model.*