Sheri L. Shulenberger, LPC-S, RPT-S™, CCST-T
Licensed Professional Counselor-Supervisor,
Registered Play Therapist-Supervisor™, Certified Clinical Sandtray Therapist-Trainer
1505 West Hunt Street, McKinney, TX 75069
972-529-7716

CHILD/ADOLESCENT INTAKE FORM

Confidential Client Information

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

To be completed by Parent or Guardian:

Child's Name:_____Today's Date:_____
Form Completed by:_____Relationship:_____
Child's Legal Guardian_____With Whom does Child Live:_____
Is the child listed in any legal document? yes/no *(If a divorce or custody suit has occurred, a copy of the entire divorce decree or court ordered parenting plan, whichever is most current, must be provided before service can be provided.) Child's age at divorce or custody suit?*_____
Child's Date of Birth_____/____/____Age:_____Gender:_____

Mother's Name:_____(May receive mail: yes/no)
Address:_____City:_____State:_____Zip:_____
Home Phone:_____(May call: yes/no; May leave message: yes/no)
Work Phone:_____(May call: yes/no; May leave message: yes/no)
Cell Phone:_____(May call: yes/no; May leave message: yes/no; May text yes/no)
You will generally receive a call or text 24 hours in advance to remind you of your appointment.
Email Address:_____(May email: yes/no)
Marital Status: ____Married ____Never married ____Separated ____Divorced ____Widowed
Number of marriages and length of each:_____
Are you currently in a custody dispute? yes/no Are you involved in a legal dispute? yes/no
Religious affiliation as a child:_____As an adult:_____

Father's Name:_____(May receive mail: yes/no)
Address:_____City:_____State:_____Zip:_____
Home Phone:_____(May call: yes/no; May leave message: yes/no)
Work Phone:_____(May call: yes/no; May leave message: yes/no)
Cell Phone:_____(May call: yes/no; May leave message: yes/no; May text yes/no)
You will generally receive a call or text 24 hours in advance to remind you of your appointment.
Email Address:_____(May email: yes/no)
Marital Status: ____Married ____Never married ____Separated ____Divorced ____Widowed
Number of marriages and length of each:_____
Are you currently in a custody dispute? yes/no Are you involved in a legal dispute? yes/no
Religious affiliation as a child:_____ As an adult:_____

Name of Person(s) to contact in case of Emergency:

1. _____Relationship:_____Phone:_____
2. _____Relationship:_____Phone:_____

Please briefly describe why you are seeking counseling for your child:_____
_____
How did you hear about me:_____

Family

Immediate Family Members (parents, siblings)

Relationship	Name	Age	Level of Education/Grade	Occupation	Does child get along with them?
Mother					
Father					
Step-Parent					
Step-Parent					
Sister(s)					
Brother(s)					
Step-Siblings(s)					
Half-Siblings(s)					

Who in your family suffers from alcoholism, eating disorder, depression or anything that might be considered mental illness, diagnosed or undiagnosed?_____
_____
Is child adopted? Yes / No When:_____
Biggest struggle in your family's history:_____
Current stressors in family:_____
Child's reaction to birth of sisters and brothers:_____
Parental unemployment? Yes / No When:_____
Any deaths your child has experience (family, friend, pet):_____
Any moves? If so, when and where:_____
Child exposed to disaster? Describe:_____
Any lengthy separation from either parent?_____
Child's contact with other children (church, sporting events, etc.)_____
_____How often?_____
What are your child's favorite activities?_____
What does your child dislike doing the most?_____
Describe your child's temperament:_____
Who is your child like?_____
What are your child's strengths?_____
What makes your child mad?_____
What are your child's responsibilities?_____

Medical Information

Primary Care Physician: Name:_____ Date of last physical:_____
Has your child ever seen a mental health professional (psychiatrist, psychologist or counselor)? Yes / No
Previous Mental Health Professional / Agency:_____
Dates of Service:_____Has your child ever been hospitalized for mental health concerns? Yes / No

Please circle the following items for which a diagnosis has been given: Depression, ADHD-Hyperactive, ADHD-Inattentive, Conduct Disorder, Learning Disability, Anxiety/Nervousness, Panic Attack, Bipolar, Schizophrenia, Oppositional Defiant Disorder, Mood/Anger, Tics, Insomnia/Sleeplessness, Obsessive/Compulsive, Addictions, Post-Traumatic Stress Disorder, Other:_____
Please list medications and dosages:_____

Current Concerns

- Adjustment to life changes (parents' divorce, move, loss/death of someone close, etc.)
- Abuse (physical, emotional, sexual)
- Aggressiveness
- Anger
- Anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, etc.)
- Behavior problems
- Bed wetting
- Bladder or Bowel control problems
- Compulsive behavior
- Crying spells
- Depressed
- Difficulty having fun
- Difficulty making friends
- Disturbing memories (past abuse, neglect or other traumatic experience)
- Divorce
- Dizziness
- Drug or alcohol use(both legal and illegal)
- Easily distracted
- Eating problems(purging, bingeing, over-eating, hoarding, severely restricting diet)
- Excessive behaviors (spending, gambling, etc.)
- Excessive boredom
- Fainting spells
- Family or Step-family relationships
- Fatigue
- Fears or phobias
- Feeling angry or irritable
- Feel lonely
- Feel panicky
- Feeling "numb" or cut off from emotions
- Feeling "on top of the world"
- Feeling ashamed
- Feeling distant from God
- Feeling fat
- Feeling guilty or shameful
- Feeling of inferiority
- Feeling "numb" or cut off from emotions
- Feeling "on top of the world"
- Feeling sadness or depression or suicidal urges *related to grief*
- Feeling sadness or depression or suicidal urges *Not related to grief*
- Health concerns (physical complaints and/or medical problems
- Hearing voices
- Hyperactive
- Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- Inability to control thoughts
- Lack of motivation
- Learning/Academic difficulties
- Loneliness
- Making/keeping friends
- Nightmares
- No appetite
- Non-family relationship problems (friend, teacher, coach, etc.)
- Palpitations
- Panic attacks
- Parent/child relationship problems
- Personal growth(no specific problem)
- Poor home environment
- Problem with alcohol
- Religious/Spiritual concerns
- Self-control problems
- Self-esteem problems
- Self-injury
- Sensitivity to sounds, noises, textures
- Sexual identity concerns
- Sexual problems/behavior
- Sleep problems (nightmares, sleeping too much or too little, etc.)
- Social skills or support
- Stress
- Suicidal thoughts
- Suspicious of other people
- Take sedatives
- Thoughts of hurting self or others
- Unable to relax
- Unable to sit still
- Unusual behavior (bizarre actions, speech, compulsive behavior, rituals, tics, motor behavior problems, etc.)
- Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- Other_____

Parenting

Discipline style:

Mom_____

Dad_____

How does each parent spend alone time with the child doing something they both enjoy?

Mom:_____How often?_____

Dad:_____How often?_____

Is spending time alone with your child pleasurable or frustrating?_____

Are you confident in your parenting ablitiies?_____

What desires do you have for your child?_____

What does your family do together?_____

Do parents support each other in parenting?_____

Additional parenting concerns:_____

_____

School History

School:_____Grade:_____

Teacher_____School Counselor_____

Special Class? Yes / No Describe_____

Current School Performance: Academic

Above average_____ Average_____ Below Average_____ Failing_____

Current School Performance: Behavior

Above average_____ Average_____ Below Average_____ Failing_____

Please describe any academic or behavioral problems your child is experiencing in school:_____

_____

When did these begin?_____Repeated a grade? Yes / No Which one?_____

What do teachers say about your child?_____

Has your child changed schools for any reason?_____

What does your child like best about school?_____

What does your child like least about school?_____

Is your child currently in any after school or daycare program?_____

Any addition comments:_____

_____

_____

_____

_____

_____

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PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: I am a Licensed Professional Counselor-Supervisor in the state of Texas, Registered Play Therapist-Supervisor™, and Certified Clinical Sandtray Therapist-Trainer engaged in private practice providing mental health services to clients directly. I am qualified to counsel adults, adolescents, children, families, parents, and groups. My area of interest and specialization is adults, adolescents, and children.

Experience: I completed my master's program at The University of North Texas. While in graduate school, I completed my student internship at the Collin County Children's Advocacy Center working with children, adults, couples, and groups. I have been counseling in private practice since May 2009.

I served as the Program Manager of The HEART Program for four years which was a nonprofit program for sexually abused children, adolescents, and their non-offending family members through Community Partners of Dallas. Prior to this time, I was the Tween victim girls (ages 9-12) group leader for two years.

I have worked as a counselor intern at Austin College, as an Admission Counselor at Glen Oaks Hospital and volunteered at the Betty Ford Center Five Star Kids Program, working with children of alcoholics/addicts and their families. For seven years, I led Created by God, a human sexuality workshop for 5th and 6th grade children through the United Methodist Church.

Nature of Counseling: The theory that guides my approach emphasizes your own resources for problem solving and puts you at the center of therapy. At times, how you see yourself is different than how you would really like to be. I believe the safe, supportive therapeutic relationship is the basis for change. I will accept, be open, sensitive, and listen empathetically to you. It is through our relationship that you will grow. You will be able to transfer things you learn about yourself in therapy to your relationships with others. We will work together during this growth process to achieve the goals you desire. I believe within you is the power for change.

INFORMED CONSENT

Counseling Relationship: Unless you prefer otherwise, I will call you by your first name. Please call me Sheri. During the time you and I work together, we will usually meet weekly for approximately 45–60-minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one. Therefore, please do not invite me to social events, bring me gifts, ask to barter, or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will benefit the most if our interactions address your concerns exclusively.

Social Media: I do not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy.

I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture of belief system, exist between us, I will work to understand those differences.

According to my professional ethical standard, I reserve the right to end a session early when and if necessary.

Effects of Counseling: At any time, you may initiate with me a discussion of possible positive or negative effects of entering or not entering into, continuing, or discontinuing counseling. I expect you to benefit from counseling. However, I cannot guarantee any specific results. Counseling is a personal exploration that 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. You may feel troubled, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. It may get worse before it gets better; I intend to work with you to achieve the best possible results for you.

Client Rights, Termination, and Referrals: Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. I hope you participate in a termination session. I also have the right to terminate the therapeutic relationship if I determine that our continued work together is not in your best interest, or if there are ethical or professional reasons that necessitate termination. If there is no word in over a year, a client is considered terminated. You also have the right to refuse or to discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. If a referral to other professionals is needed, you will be provided with some alternatives, including programs and/or people who may be available to assist you.

NOTICE TO CLIENTS

The Texas Behavioral Health Executive Council (BHEC) investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology.

Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Please call 1-800-821-3205 for more information.

I render counseling services in a professional manner consistent with accepted ethical standards as stipulated by the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time for any reason you have concerns or are dissatisfied with my services, please let me know. You may report any complaints.

The contact information for this agency is:
Texas State Board of Examiners of Professional Counselors
Texas Behavioral Health Executive Council (BHEC)
333 Guadalupe St, Suite 3- 900
Austin, TX 78701
(512) 305-7700
(800) 821-3205 24-hour, toll-free complaint system

https://www.bhec.texas.gov/

Appointments, Cancellation, and Crises: Our in-person contact will be limited to counseling sessions you arrange with me. If you are unable to keep an appointment, please notify me at 972-529-7716 at least 24 hours in advance. Although I do take into consideration personal emergencies and extenuating circumstances, fees will still be charged for appointments missed.

I shall always try to return your call within 24 hours if not sooner. I am not an emergency mental health service.

If you or your child need emergency help at a time when your counselor is not available, it is your responsibility to call 911 or go to the nearest hospital emergency room.

If you or someone you know is experiencing a mental health crisis, please know that support is available 24/7. You can reach a trained crisis counselor by calling or texting 988, or by chatting at 988lifeline.org.

Fees: The initial intake session, for adults/parents only, is approximately 55-60 minutes and the fee is $140.00. Each subsequent session is 45-60 minutes, and the fee is

$140.00. Payment is required at the time of the session and is the responsibility of the parent who brings the child to the office for treatment. Acceptable methods of payment are cash, PayPal, Venmo, Zelle or checks payable to Sheri L. Shulenberger. I am an out-of-network provider and do not verify insurance coverage, file insurance claims nor receive insurance payments. Upon request, a receipt with the necessary coding for you to self-file with your insurance company will be provided.

No Surprises Act: I am committed to transparency in my billing practices. Under the No Surprises Act, I am required to provide a Good Faith Estimate (GFE) of the expected cost of services to clients. The GFE can be provided. Please note the GFE is an estimate, and actual charges may vary.

The rate for all related counseling services, including but not limited to, time incurred due to phone calls over 5 minutes, medical concerns, psychiatric concerns, home and family social studies, child protective service cases, adoption and foster care, issues of divorce, child custody, attorney consultation, education concerns, behavioral concerns, ARD meetings, classroom observation, interactions with insurance providers, etc., will be bill at $140.00 per hour in 15 minute increments. In the case of off-site services, the fee includes travel time to and from 1505 West Hunt Street, McKinney, TX 75069.

Court: Please know that being a witness is not in my area of interest or expertise. If you are seeking counseling for court or court-related purposes or motivation, I will provide you with alternative appropriate referral sources. Should you, your attorney, your spouse, or ex-spouse's attorney, subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay $420.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to court-related process. You further agree to pay a retainer fee of $4,000.00 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me, it will be turned over to my attorney, and you will be billed for any attorney fees I incur on your behalf. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.
Please note: 24-hour advanced notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24-hour notification is not made, a fee of $3,360.00 will be billed. (8 hour @ $420.00 per hour)

Confidentiality and Records: What we talk about in the counseling session is confidential. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first.

Possible exceptions include but are not limited to the following situations:

1. I determine any information revealed in session indicates physical, sexual, or emotional abuse or illegal neglect of children, or abused, neglect, or exploitation of elderly or disabled persons.
2. I determine you are a danger to yourself; your child is a danger to him/herself or others.
3. I am ordered by the court to disclose information.
4. You (parent or legal guardian) sign a written consent.
5. If you or your child receives concurrent services from another practitioner, we are both obligated to disclose our involvement to one another.
6. I learn of sexual exploitation by another mental health services provider.
7. I receive supervision and/or consultation regarding your case without mentioning names, details and identifying information to provide you with quality care.

In the event of my death, there is an established plan for the custody of my records.

All communication becomes part of the clinical treatment.

Email and Text Messages: I use and respond to email and text messages only to arrange or modify appointments. Please do not send emails related to treatment or therapy sessions as electronic communications are not completely secure and confidential.

Video or Audio: You acknowledge and, by signing this information and consent form below, agree that neither you nor I will record any part of your sessions unless you and I mutually agree in writing that the session may be recorded. You further acknowledge that I object to your recording any portion of your sessions without my written consent.

CONSENT TO TREATMENT

I, voluntarily, agree to receive and authorize Sheri L. Shulenberger, LPC-S, RPT-S™, CCST-T to provide such care, treatment, or services that are considered necessary and advisable for me and/or my minor child.

I have the legal authority to seek professional services for my minor child.

By my signature below, I acknowledge reading and understanding this document, and any questions I had were answered and I was furnished a copy of this document.

I engage Sheri L. Shulenberger, LPC-S, RPT-S™, CCST-T to render services as provided herein.

Client signature (parent/guardian if minor)_____Date_____

Client signature (parent/guardian if minor)_____Date_____

Child's Name_____Date_____

I have provided Sheri L. Shulenberger, LPC-S, RPT-S™, CCST-T with the latest custody order and/or divorce decree.

Parent signature_____Date_____

Acceptance by Counselor

Counselor's Signature _____Date_____

CONSENT TO PHOTOGRAGH AND STORE EXPRESSIVE ARTS

Assessment tasks and treatment services are significantly enhanced by the use of photographing and storing expressive arts products, including photos of sand tray scenarios, drawings, or storage of arts and crafts. Photographs of art or sand tray scenes assist in reviewing and documenting thematic materials following a session, promoting a more in-depth exploration of the work completed which may include soliciting peer feedback and consultation.

All identifying information is removed prior to using the materials for the above purposes. Your consent is completely voluntary, and non-participation will not interfere with the assessment or therapy service you have requested.

I have read the above consent form and have had the opportunity to ask questions which have been answered to my satisfaction.

I agree to allow expressive therapy work (sand tray or art) to be photographed and used for the following purposes.

Client signature (parent/guardian if minor)_____Date_____

Client signature (parent/guardian if minor)_____Date_____

Child's Name_____Date_____

Acceptance by Counselor

Counselor's Signature _____Date_____

HIPPA Notice of Privacy Practices

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 notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health insurance may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students and Licensed Professional Counselor Interns who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object, unless required by law. You may revoke this authorization in writing at any time, except to the extent that your therapist or therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices for this office:

Client signature (parent/guardian if minor)_____Date_____

Consent for Use and Disclosure of Health Information:
I hereby permit and release Sheri L. Shulenberger, LPC-S, RPT-S™, CCST-T to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or to other governmental third-party payors, or any organization contracting with any of the above entities to perform such functions.

Client signature (parent/guardian if minor)_____Date_____

You have the right to request restrictions of uses on disclosure of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.