Ingela Edwards, LPC, NCC, SRT, CCPS
250 Adriatic Parkway, Suite 102
McKinney, Texas 75072
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Phone: 214-551-0422

CLIENT INFORMATION

Name	Legal Name (if different)	Former Name	Date of appointment

Date of Birth	Age	Social Security Number	Ethnicity/Nationality	Sex Male / Female

Street Address	City	State	ZIP	Cell Phone

PO Box	City	State	ZIP	Home Phone

Occupation	Employer	Work Phone

e-mail address	Alternative e-mail address

Gross Annual Household Income:

☐ Less than $40,000 ☐ $40,000-$49,999 ☐ $50,000-$59,999 ☐ $60,000-$69,999	☐ $70,000-$79,999 ☐ $80,000-$89,999 ☐ $90,000-$99,999 ☐ $100,000-$114,999	☐ $115,000-$129,999 ☐ $130,000-$144,999 ☐ $145,000-$159,999 ☐ $160,000-$174,999	☐ $175,000-$199,999 ☐ $200,000-$249,999 ☐ $250,000-$299,999 ☐ $300,000+	How many in household? _____ How many other family members currently in therapy? _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to Client	Home Phone	Work Phone

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

_____ _____

X Client/Guardian Signature Date

If you will be filing for insurance reimbursement, please write your name as it appears on your insurance card, the name of your insurance company and your policy/account number.

_____

PRESENTING PROBLEMS:
Why are you coming to therapy *now*? (What are the symptoms? When did the problem start? How often does it happen? How does it affect you? What have you tried to solve it? What helps? Makes it worse?).

What are you hoping will be different as a result of coming to therapy? What are your specific goals for therapy?

Check the items that describe how you have been feeling lately:
☐ no problems ☐ sad ☐ depressed ☐ worthless ☐ hopeless ☐ helpless ☐ restless ☐ worried ☐ anxious ☐ scared ☐ guilty ☐ ashamed ☐ angry ☐ aggressive ☐ resentful ☐ irritable ☐ confused ☐ mood swings ☐ jealous
Describe any other feelings you have had:_____

Check all the sleep problems that apply: ☐ No Problems ☐ trouble getting to sleep ☐ trouble staying asleep ☐ waking up early ☐ fragmented sleep ☐ poor sleep quality ☐ nightmares
Is this a change or a longstanding problem?_____

Check all that apply for your appetite:
☐ normal ☐ less than normal ☐ force myself to eat ☐ lost weight ☐ more than normal ☐ gained weight ☐ currently dieting

Please circle the number for the items below. If it does not apply, leave blank.

Concern	***Very Dissatisfied***				***to***					***Very Satisfied***
Household Responsibilities	1	2	3	4	5	6	7	8	9	10
Children	1	2	3	4	5	6	7	8	9	10
Sex	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Sexual Identity	1	2	3	4	5	6	7	8	9	10
Independence/Dependence	1	2	3	4	5	6	7	8	9	10
Spouse/Partner	1	2	3	4	5	6	7	8	9	10
Relatives	1	2	3	4	5	6	7	8	9	10
Spirituality	1	2	3	4	5	6	7	8	9	10
Alcohol	1	2	3	4	5	6	7	8	9	10
Drugs	1	2	3	4	5	6	7	8	9	10
Jealousy	1	2	3	4	5	6	7	8	9	10
Infidelity	1	2	3	4	5	6	7	8	9	10
Sexual Compulsivity	1	2	3	4	5	6	7	8	9	10
Career/Work	1	2	3	4	5	6	7	8	9	10
Physical Health	1	2	3	4	5	6	7	8	9	10

BACKGROUND INFORMATION:
Family
Relationship Status: ***Check all that apply***
☐ Never Married ☐ Married ☐ Separated ☐ In home separation ☐ Divorced ☐ Widowed ☐ Living Together
Number of: _____ marriages _____ divorces _____ serious relationships

If currently married/living together, how long? _____ If widowed, separated or divorced, how long? _____

***List Children**: Name:*	*Age:*	*Relationship (biological, step):*	*Lives with:*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List other members of household: _____

Any history or abusiveness in your current or past serious relationships? ☐ Yes ☐ No _____

Any history of/or concern about infidelity in your current or past relationships? ☐ Yes ☐ No _____
Any history of sexual assault or date rape? ☐ Yes ☐ No

Family of Origin:

Where were you born?_____ Where did you grow up? _____
Were your parents together when you were born? ☐ Yes ☐ No

Check all information that applies to your biological parents:

Mother	Father	
☐ living	☐ living	Do you consider someone else to be your 'real' parents (e.g., step-parent, grandparent, etc.)? If so, describe: _____
☐ deceased	☐ deceased	_____
☐ married	☐ married	_____
☐ divorced	☐ divorced	
☐ remarried _____ # of times	☐ remarried _____ # of times	

If your parents split up, how old were you when this happened? _____

Your relationship with your parents growing up was: ☐ Poor ☐ Fair ☐ Good ☐ Better with mom ☐ Better with dad
Your relationship with your parents now is: ☐ Poor ☐ Fair ☐ Good ☐ Better with mom ☐ Better with dad

List the names and ages of your brothers & sisters, including you, in the order of birth.

Name	*Age*	*Relationship (natural, half, step, adopted, etc.)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did your family experience significant economic hardship while you were growing up? ☐ Yes ☐ No

Circle if there were any family problems while growing up related to:
☐ Alcohol ☐ Drugs ☐ Sex or Love Addition ☐ Infidelity ☐ Other Addictions:
☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Neglect: ☐ Parental depression/ Anxiety
Please explain: _____

Health History

Name of primary care physician: _____
Address: _____ Phone number: _____
Date of last appointment: _____ Date of next appointment: _____
OK to discuss your care with your doctor: ☐ Yes ☐ No
Name of current & past psychiatrists: _____
Address: _____ Phone number: _____
Date of last appointment: _____ Date of next appointment: _____
OK to discuss your care with psychiatrist: ☐ Yes ☐ No

Current Medications:	*Dose/Freq*	*Start Date*	*Purpose*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for medical or psychiatric reasons? ☐ Yes ☐ No

Hospital	Date	Reason

Please check all that apply:

Condition	Yes	Dates	Condition	Yes	Dates
Asthma/Respiratory			Hearing Problems		
Tuberculosis			Paralysis		
Pneumonia			Shaking/Tremors		
Hemorrhoids			Convulsions/Epilepsy		
Headaches/Migraines			Diarrhea		
High/Low Blood Pressure			Neurological Problems		
Constipation			Ulcer		
Diabetes			Anxiety		
Heart Condition			Depression		
Back Problems			Thyroid Problems		
Fainting			Chronic Pain		
Cancer			Tumors		
Fibromyalgia			Mastectomy		
Abortion			Miscarriage		
Menstrual Problems			Hysterectomy		
Menopausal			Hormone Replacement Therapy		
Sterility			Vasectomy		
Low Sexual Desire			Impotence		
Pain with Intercourse			Erectile Dysfunction		
Difficulty with Orgasm			Premature/Inhibited Ejaculation		
Accident (serious)			STD		
Surgery (major)			Other		

List any over the counter medications, sleeping pills, supplements, herbs, etc. that you regularly take that are not listed above:
_____
_____
Describe any important medical history, chronic ailments, or other health problems you experience: _____
_____
_____

Describe any serious medical problems, chronic ailments, or other health problems that family members and other loved ones are dealing with that contributes to your stress: _____
_____
_____
_____

Past History of Counseling/Therapy:
Have you ever been in counseling, psychotherapy or marital/family/group therapy before? ☐ Yes ☐ No

Dates of Treatment	*Reason for Therapy*	*Therapist or Agency*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any close relatives (parents, siblings, grandparents, etc.) who have a history of depression, anxiety, or other emotional problems? ☐ Yes ☐ No If yes, explain: _____

Have you ever **considered suicide** in connection with your **current** problems? ☐ Yes ☐ No
If so, please describe, with dates: _____
_____

Have you ever **considered suicide** in the **past**? ☐ Yes ☐ No
If so, please describe, with dates: _____
_____

Have you **attempted suicide recently** or in the **past**? ☐ Yes ☐ No
If so, please describe, with dates: _____
_____

Have you had any thoughts of **hurting anyone else recently**, or in connection with your **current** problems?
☐ Yes ☐ No *If yes, explain:* _____

Have you ever **considered hurting someone** else in the **past**? ☐ Yes ☐ No
If yes, explain: _____

Circle any problems with daily functioning: ☐ isolating from friends/family ☐ starting or completing work ☐ completing daily tasks ☐ getting along with family or coworkers ☐ severe financial stress Describe any other problems: _____
_____

Please check any of the following that apply to you:
☐ *I sometimes hear voices even though no one is talking to me.*
☐ *I sometimes feel that forces outside of me control me.*
☐ *I sometimes feel that other people control my thoughts.*
☐ *I sometimes have the same thought over & over and can't control it.*
☐ *I sometimes feel that someone is out to hurt me or do something to me.*
☐ *I sometimes am unable to control my behavior.*
Please explain: _____

What is your history of use of the following?

Substance	Current Use				Past Use		
	How much	*How often*	*For how long*	*Last use*	*How much*	*How often*	*If quit, when*
Cigarettes/Tobacco							
Alcohol							
Marijuana							
Cocaine							
Meth							
Heroin							
Inhalants							
Pain medicine							
Sleep medicine							
Other(s)							

Please check for your exposure to addictive behaviors and/or behaviors that others have expressed concern about for you:

Behavior	Yes	By You	Family Member	Relationship Partner	Behavior	Yes	By You	Family Member	Relationship Partner
Alcohol					Love Addiction				
Recreational Drugs					Food/Eating				
Prescription Drugs					Shopping				
Gambling					Codependency				
Sex					Video gaming				
Masturbation					Internet				
Pornography					Facebook/Social Media				
Texting					Other				

Have you ever been in rehab, treatment program, or attended 12-Step meetings for an addictive or substance disorder?
☐ Yes ☐ No If yes, please describe: _____
_____

Personal & Social History

Any developmental, academic, or behavior problems while in school, with peers, or with teachers? ☐ Yes ☐ No
If yes, what _____
What was the last year of school you completed? _____
What is your usual occupation? _____
Have you ever had trouble keeping a job? ☐ Yes ☐ No If yes, why? _____
_____

Do you have any serious outstanding debts? ☐ Yes ☐ No If yes, explain _____
_____
Any current legal difficulties, including law suits? ☐ Yes ☐ No Explain: _____
_____
Are you concerned about future legal involvement, including divorce? ☐ Yes ☐ No Explain: _____
_____
Any past legal difficulties? ? ☐ Yes ☐ No Explain: _____
_____
Ever investigated by Child Protective Services? ☐ Yes ☐ No Adult Protective Services ? ☐ Yes ☐ No
Explain:_____
Have you ever filed a complaint against a professional? ☐ Yes ☐ No
What special cultural or ethnic customs do you participate in? _____

What spiritual or religious practices are important to you? _____
Do you attend a place of worship? ☐ Yes ☐ No If yes, name of place of worship you attend _____

Resources

How often do you participate in regular exercise? _____

What activities or recreational outlets do you enjoy? _____
_____

Are you currently participating in those activities with the same frequency and same level of pleasure? ☐ Yes ☐ No
Besides family, how many people can you count on for friendship or emotional support? _____

Military History

Any history of military service? ☐ Yes ☐ No
Are you the spouse or significant other of a veteran or military personnel? ☐ Yes ☐ No

Military branch? _____
War time? ☐ Yes ☐ No Combat? ☐ Yes ☐ No Injured? ☐ Yes ☐ No POW? ☐ Yes ☐ No
Where? _____ Service dates: from_____ to _____
Number of deployments? _____ Highest rank at discharge? _____
Early discharge? ☐ Yes ☐ No If yes, explain:_____
Any awards or medals? _____ Any disciplinary actions? ☐ Yes ☐ No
List any current problems related to military service: _____

Any history of military service for your spouse ? ☐ Yes ☐ No Service dates: from_____ to _____

Trauma History

Please check if you have experienced any of the following kinds of events. For the events you check "Yes", please indicate the number of times that kind of event has happened to you.		*# of times this has happened*
☐ Yes ☐ No	A really bad accident at work or home	
☐ Yes ☐ No	A really bad car, boat, train, or airplane accident	
☐ Yes ☐ No	A really bad accident at work or home	
☐ Yes ☐ No	A hurricane, flood, earthquake, tornado, or fire	
☐ Yes ☐ No	Hit or kicked hard enough to injure – as a child	
☐ Yes ☐ No	Hit or kicked hard enough to injure – as an adult	
☐ Yes ☐ No	Forced or made to have sexual contact – as a child	
☐ Yes ☐ No	Forced or made to have sexual contact – as an adult	
☐ Yes ☐ No	Attack with a gun, knife, or weapon	
☐ Yes ☐ No	During military service – seeing something horrible or being badly scared.	
☐ Yes ☐ No	Sudden death of close family or friend.	
☐ Yes ☐ No	Seeing someone die suddenly or get badly hurt or killed	
☐ Yes ☐ No	Some other sudden event that made you feel very scared, helpless, or horrified	
☐ Yes ☐ No	Sudden move or loss of home and possessions	
☐ Yes ☐ No	Suddenly abandoned by spouse, partner, parent, or family	

Please write any other information you think is important for understanding your situation below.

THANK YOU!

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Welcome

This document contains important information about the counseling services and business policies. Please read it carefully and write down any questions you have so we can discuss them when we meet. When you sign this document, it will represent an agreement between us. However, the 'therapist-client' relationship does not exist until after the initial assessment is completed and we have decided to move ahead, as evidenced by your signature on this form.

CREDENTIALS: Ingela Edwards has a Master's Degree in Counseling and Development from Texas Woman's University. Ingela is a Licensed Professional Counselor (LPC), National Certified counselor (NCC), Certified Clinical Partner Specialist (CCPS) and a certified Sexual Recovery Therapist (SRT).

COUNSELING SERVICES: Counseling focuses on developing ways to address your particular concerns about your life. In the first sessions, your needs and goals will be identified, as well as the most appropriate treatment options. If your therapist cannot provide the appropriate service to address your needs, you may be referred to other sources of treatment. While your therapist will ask about many areas of your life, the focus of the therapy will be on working toward your specific goals. To get the most out of therapy, you must take an active role. This involves discussing your concerns openly, completing any assignments and providing feedback to your therapist about the progress of the therapy.

Often, personal growth includes facing issues that cause sadness, sorrow, anxiety or pain. Your therapist will support you as you make choices and changes in your life. Therapy can facilitate self-awareness, better understanding of relationships, and achievement of personal goals, although there are no guarantees of what results you may experience. It is possible that therapy may not resolve your problem, or that therapy alone may not be sufficient. Should this be the case, the therapist will explore alternative plans with you.

If there is current or prior involvement with any other professional (doctor, therapist, counselor, probation officer, etc.), you may be asked to sign a *Release to Exchange Information* form that allows your therapist to contact them. You will also complete a questionnaire at the beginning of your therapy. This allows your therapist to provide you the best possible care.

MEETINGS: The standard session is 45-50 minutes. It is recommended that counseling sessions are scheduled on a weekly basis. Sessions may be longer and we may meet more or less frequently. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. A necessary element of the therapy process is the client's commitment to attend sessions regularly. You may stop therapy at any time, but the therapist needs to be informed before your last session.

PROFESSIONAL FEES: The current fee for a standard (45-50minute) session is $150.00. The fee for longer or shorter sessions is prorated based on the standard session fee. In addition to weekly appointments, the same hourly fee is charged for other professional services, although the hourly cost will be broken down for

periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 6 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, copying your file (30c per page with a $2.00 minimum that must be paid in advance), and the time spent performing any other professional service. If you become involved in legal proceedings that require the participation of your therapist, you will be expected to pay for the professional time of your therapist even if your therapist is called to testify by another party. Your therapist will not agree to court appearances at your request or other legal involvements unless the matter has been thoroughly discussed and both you and your therapist agree that such involvement is within the range of competence of your therapist and will not interfere with the treatment relationship. Because of the difficulty of legal involvement, there is a $350 per hour charge for travel, wait time, telephone consultation with attorneys and research in preparation for testimony with a 4 hour minimum to be paid in advance for preparation and attendance at any legal proceeding.

BILLING & PAYMENTS: You will be expected to pay for each session at the time of service. Payment schedules for other professional services will be agreed to when they are requested. You may pay with cash, credit card or check. Checks returned for non-sufficient funds will incur a $30 service fee in addition to fees assessed by the bank. This fee and the value of the check must be paid in cash or by credit card before another session can be scheduled, and checks may then no longer be accepted. When your course of therapy ends, your account must be paid in full. Payments by credit cards will be in accord with the pre-authorization for health care form provided by this office.

MISSED APPOINTMENTS: For any scheduled appointments, please give at least 24-hour advance notice of the cancellation. You will be charged for missed appointments and cancellations unless you cancel with no less than 24 hours of the appointment, unless waived on a case-by-case basis. The fee for missed appointments and late cancellations (less than 24 hours notice) is the full fee as described above. With the signature below, you will authorize the therapist, Ingela Edwards, LPC, NCC, SRT, CCPS to charge credit cards for late cancellation and missed session appointment fees when incurred. Such charges are payable immediately and will be automatically charged to your credit card.

INSURANCE: Ingela Edwards is an out of network provider and can provide you with the appropriate receipts needed for potential insurance reimbursment. It is your responsibility to verify your coverage for insurance reimbursement and to file your own claims if applicable.

EMERGENCIES: *Your therapist is not available 24 hours a day and does not provide formal emergency services*. In the event of an emergency or crisis between scheduled appointments, you may call the Contact Counseling & Crisis 24-Hour Line at 972-233-2233 (adults) or 972-233-8336 (teens) or the Suicide Crisis Center 24-Hour Line at 214-828-1000 (all ages), 911 or go to the nearest emergency room for immediate care.

CONTACTING YOUR THERAPIST: The best way to contact your therapist is by telephone, although your therapist may not be immediately available. Your therapist will make every effort to return your call within the same day, with the exception of after hours, weekends and holidays. For simple rescheduling issues, e-mail is often the fastest, most convenient method for communication. If you choose to communicate via e-mail, remember that the internet is not a secure medium for transmitting confidential information. Your therapist will not accept friend requests from clients on social media.

PROFESSIONAL RECORDS: Your therapist is required to keep records of your counseling sessions for a period of 5 years after the date of your last session. These records include dates of treatment, case notes, correspondence, progress notes and billing information.

MINORS: If you are under 18, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request a parental agreement to give up access to your records. If they agree, I will provide them with only general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else.

CONFIDENTIALITY*:* The information shared by you or your family members in this session and any future sessions will remain confidential with some exceptions, including the following:

1. You have given written authorization to release information.
2. A court orders records or therapist testimony.
3. Your therapist has reason to believe that there is a serious risk of imminent danger to yourself or to someone else.
4. Your therapist has reason to believe or suspect that a child, disabled person, or elderly person has been or may be abused or neglected.
5. Known or suspected sexual exploitation of a client by a past therapist
6. In the case of minors, the parent or legal guardian has a right to receive information about the counseling their minor child is receiving, and non-custodial parents or others may have rights to information in accordance with court orders.
7. Communications with any third-party payers necessary for payment of fees or as may be necessary to collect an outstanding balance on your account.

In the case of multiple clients in a session, such as family or couples therapy, each individual in the counseling unit must provide written permission for any release of information. Please note that with couples and family therapy the couple or the family is the client (i.e., the counseling unit), not the individuals involved. Your therapist practices a *no-secrets policy.* Confidentiality does not apply among members when one member is seen in an individual session or contacts the therapist outside of the therapy session to share information. Your therapist reserves the right to disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support overall treatment progress and goals.

Your therapist may also find it helpful to consult with other professionals about your case. If so, your identity will not be revealed

COMMITTMENT TO COUNSELING: A necessary element of the counseling process is your commitment to attend sessions regularly. You may stop the counseling at any time, but please inform your therapist before your last session. Attending sessions under the influence of alcohol or drugs or in possession of a weapon is not allowed.

GRIEVANCE PROCEDURE: It is important to your therapist that you are satisfied with your therapy experience. If at any time, for any reason, you are dissatisfied with the services, please let your therapist know. If the issue remains unresolved, you may report your complaint to The Texas State Board of Examiners of Professional Counselors, Complaints Management and Investigative Section, P.O Box 141369, Austin, TX 78714-1369 or phone (800)942-5540.

Your signature below indicates that you have read, understand, and agree to the information in this document.

Signature of Client or Responsible Party	Driver's License Number	Date

Printed name of Client or Responsible Party

Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of 'Notice of Privacy Practices'

Signature of Client or Responsible Party

Relationship of Personal Representative to Client

Consent to Method of Contact

Home number: _____ OK to leave msg? ☐Yes ☐No

Cell/Text Number: _____ OK to leave msg? ☐Yes ☐No

Other Number: _____ OK to leave msg? ☐Yes ☐No

E-mail: _____ OK to leave msg? ☐Yes ☐No

OK to send appointment confirmation via method of contact you have approved above? ☐Yes ☐No

OK to send receipts, future updates, and information about Ingela Edwards' practice? ☐Yes ☐No

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Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In case of late cancellations and/no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $30 in addition to fees assessed by my bank will be charged for returned checks. In the case of extended telephone consultations, participation in legal proceedings, or other administrative activities you will be charged a fee as specified in the 'Professional Fees.'

I, _____, am authorizing Ingela Edwards, LPC, NCC, SRT, CCPS to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance, or a check is returned for any reason as agreed to in the office policies stated in the signed 'Welcome Information & Missed Appointment section.' I agree I will not dispute those charges (charge back). This form may be updated upon request or as additional credit cards are utilized for rendering payment.

Card Type (circle one): Visa MasterCard Discover

Card #:_____ Expiration Date:_____

Name as Printed on Card: _____

(In filling out "Name as Printed" section you are confirming that you are authorized to use the card of the above named individual.)

Verification/Security Code (3 digit code on back of card by signature line):_____

Billing Address:_____

City:_____ State: _____ Zip:_____

By signing below I am authorizing Ingela Edwards, LPC, NCC, SRT, CCPS to charge for scheduled appointments/office fees associated with services provided.

Signature:_____ Date:_____