Family Counseling Intake Form
Carrie Austin, MA, MA, LMFT
(512)870-8331

Parents' (Guardian's) Name(s) _____

Primary Address _____ **City** _____ **St** _____
Zip_____ **Home Phone** _____ **Cellphone** _____

Father's Address_____ **City** _____ **St** _____
Zip_____ **Home Phone** _____ **Cellphone** _____
E-mail Address: _____ **DOB** _____
Father's Emergency Contact
Name_____ **Relation** _____
Phone _____

Mother's Address _____ **City** _____
Zip_____ **Home Phone** _____ **Cellphone** _____
E-mail Address: _____ **DOB** _____
Mother's Emergency Contact
Name_____ **Relation** _____
Phone _____

How did you find me? □ **Google Search** □ **Psych Today** □ **Referral**
□ **Other** _____

Reason for seeking Services Today:
_____
_____

Employment

Please check father's employment status:
___employed full-time ___employed part-time ___unemployed ___disabled ___retired

If currently employed, please list job information below:
Employer Job Title How long there?
_____ _____ _____
Work Phone: _____ Is it ok to contact you at this #? Yes No

Please check mother's employment status:
___employed full-time ___employed part-time ___unemployed ___disabled ___retired

Mother's Work Phone: _____ Is it ok to contact you at this #? Yes No

If currently employed, please list job information below:

Employer	Job Title	How long there?
_____	_____	_____

Work Phone: _____ Is it ok to contact you at this #? Yes No

Family/Living Situation

____Single ____Partnered ____Married ____Separated ____Divorced ____Widowed

If married, how long together? _____

Children:

_____	Age:_____	Living with you?	Yes No
_____	Age:_____	Living with you?	Yes No
_____	Age:_____	Living with you?	Yes No
_____	Age:_____	Living with you?	Yes No
_____	Age:_____	Living with you?	Yes No

Counseling/Prior Treatment History

Have you or any family members had any prior professional counseling or psychiatric treatment? ___ Yes ___No

If yes, please list most recent treatment episodes, treatment provider, and outcome below:

Person receiving treatment	Approx. Treatment Dates	Treatment Provider	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication and Chemical Use History

Father:

Have you ever been treated for alcohol or drug dependence/abuse? ____Yes ____No

Have you ever felt like you should cut down on alcohol or other drug use? ____Yes ____No

Has a friend or relative ever discussed concerns about your drug use? ____Yes ____No

Have you ever felt guilty about your drinking or drug use? ____Yes ____No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __Yes ____No

Is there a history of problems with alcohol or drug use in your family? ____Yes ____No

Medication and Chemical Use History (cont'd)

Mother:

Have you ever been treated for alcohol or drug dependence/abuse? ____Yes _____No

Have you ever felt like you should cut down on alcohol or other drug use? ____Yes _____No

Has a friend or relative ever discussed concerns about your drug use? ____Yes _____No

Have you ever felt guilty about your drinking or drug use? ____Yes _____No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___Yes ____No

Is there a history of problems with alcohol or drug use in your family? ____Yes ____No

Parents' Medical History

Father:

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)

_____

Use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency:

_____

Primary Care Physician: _____ Phone:_____Last seen on: _____

Current medications: Name Dosage Frequency

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication Allergies:

_____

Other Allergies:

_____

Mother:

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)

_____

Use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: _____

Primary Care Physician: _____Phone:_____Last seen on: _____

Mother's Medical History (cont'd)

Current medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:

_____

Other Allergies:

_____

Family History/Development

List any pertinent family history of medical, mental health, or substance abuse problems: ___

Has any family member(s) been a victim of sexual, physical, emotional, or verbal abuse?
__Yes __No. If yes, please explain_____
_____

Are there other unusual/traumatic circumstances that affected your family's development?
__Yes__No

If Yes, please describe: _____

Are there any open CPS cases involving members of the family? Yes No
Are there any legal cases/issues your family is facing? Yes No

I understand that Mrs. Austin believes it is in the best interest of the families/ individuals she helps to not get involved in custody disputes and court proceedings. The services she provides are focused on family members' relational and emotional well-being. Legal advice is beyond her scope of practice.

_____ (Father's Initials) _____ (Mother's Initials)

Spiritual History

Father's Religious upbringing_____Present Affiliation_____

Is this an important part of your life?_____Why/why not?_____

Where are you at spiritually right now?_____

_____

Mother's Religious upbringing_____Present Affiliation_____

Is this an important part of your life?_____Why/why not?_____

Where are you at spiritually right now?_____

_____

****Please fill out "Additional Child Family intake" form for each additional child.**
Yes, there are additional children_____ No, there are no additional children_____

CHILD 1

Name:_____ DOB:_____
School:_____ Grade:_____
How does your child do in school academically? _____
How does your child do in school behaviorally?_____
Does your child have a learning or physical disability? __Y, __N, __Maybe.
Specify: _____
Does your child have a mental health diagnosis? __Y, __N,
Specify: _____
Biological Dad:_____ DOB: _____
Biological Mom:_____ DOB: _____
__/__/__ Married; __/__/__ Separated; __/__/__ Divorced
Siblings (1st to last):
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Custodial Adults (If not biological parents):
Name: _____ DOB:_____ Date became caretaker: _____
Name: _____ DOB:_____ Date became caretaker: _____
People in household, if different from above:
_____

Father's highest level of education: _____

Mother's highest level of education: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

Has children witnessed domestic violence? __Y, __N, Specify: _____
_____

How is your child disciplined? Please list each method and frequency of use: _____
_____

Trauma History

Has child 1 been verbally abused? __Y, __N, __Suspected. Specify: _____
_____

Has child 1 been physically abused? __Y, __N, __Suspected. Specify: _____
_____

Has child 1 been sexually abused? __Y, __N, __Suspected. Specify: _____
_____
Other stressors or traumas? _____
_____

Check the symptoms child 1 displays and list the number of times per week symptom is displayed:

__Anger	__Hyperactivity	__Nightmares
__Anxiety	__Hyper vigilance	__Plays out sexual themes
__Bed wetting	__Impaired conscience	__Obsesses
__Acts out sexually	__Isolation	__Over/Under eating
__Conduct problems	__Lack of empathy	__Phobias
__Controlling Day defecation	__Lack of motivation	__Peer problems
__Has unusual sexual	__Lethargy	__Running Away
knowledge	__Low impulse control	__Shy
__Day wetting	__Plays out violent themes	__Sleeplessness
__Defiance	__Low self-esteem	__Stealing
__Depression	__Disassociates	__Tantrums
__Homicidal thoughts or actions	__Drug or alcohol use	__Somatic Symptoms:
__Disassociates	__Lying	(Headaches, stomachaches,etc.)
__Drug or alcohol use	__Masturbates excessively	Other: _____

How does child 1 handle anger? _____
_____

Has child 1 experienced any significant loss? _____If yes, explain:_____
_____

What do you view as your child/teen's major strengths and positive traits? _____
_____

What are your child/teen's hobbies? _____
_____

Where do you believe your child/teen is spiritually?_____
_____

Briefly describe your goals for child 1's therapy: _____
_____

Please list any information you deem to be important for the therapist to know about Child 1:
_____
_____

Tell anything else in the space below that you think would be helpful for me, as your Family Therapist, to know. _____

Please state what kind of family goals you would like to work on in therapy_____
_____
_____
_____

Carrie Austin, MA, MA, LMFT
(512)870-8331

Informed Client Consent

Counselor Qualifications and Experience
I received my Bachelors of Arts degrees in Psychology and Studio Art from the University of Mobile in Mobile, Alabama. I received my Masters of Arts degrees in Marriage and Family Counseling and Religious Education from Southwestern Baptist Theological Seminary in Ft. Worth, Texas. I am licensed as a Marriage and Family Therapist. What this means is that I have completed all educational, testing and supervision requirements for practicing Marriage and Family Therapists in the state of Texas.

Confidentiality
Everything you discuss during sessions will be kept confidential, except matters pertaining to (1)the intention to harm self or others, (2) the physical/sexual abuse and/or neglect of minors, persons with disabilities, and the elderly, (3) legal activity resulting in a court order or anything else required by law. Information may also be released if you request and sign a Release-of-information form.

In the case of couple or family therapy, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's permission. I do not disclose client confidences and information to any third party except for materials shared during supervision without a client's written consent except when mandated or permitted by law. When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. In the case of minor children (under the age of 18), the parents or managing conservator may legally request information concerning the child's progress and treatment. I will maintain confidentiality with minors and work with them to make disclosures to parents in a way that will preserve the therapeutic relationship.

Counseling Philosophy
My counseling philosophy comes from a systems approach to relationships. I find great value in the cognitive/ behavioral approaches but believe strongly in the power of the family system on a person's past, present and future. With an Christian worldview, I seek to support clients through a safe and caring therapeutic relationship in which clients can explore concerns, set goals, and embrace the fullness that life can bring.

About Counseling
I am an advocate of individual, family, and group therapy as a process of change. However, it is important that clients understand the nature of the therapeutic process so that they will know what to expect. The following represent a partial list of answers to common questions and expectations. Please feel free to ask any additional questions.

1. Counseling is a collaborative effort between the client and counselor. The counselor only facilitates change; she cannot make changes happen.

2. The efficacy of counseling (the power to produce results) develops through the therapeutic relationship. Therefore, it is important that the client feels safe and comfortable while working with his/her counselor. While this takes time, it also requires that the client be honest about their behavior and any concerns they may have about counseling or their counselor
3. The process of change can be uncomfortable.
    a) Clients may have insights, memories or otherwise gain information that may be unpleasant.
    b) Clients may experience loss in relationships as they discover and change behavior.
    c) Families and individuals often experience escalations in problems before they experience improvements.
    d) Family members and significant others may be reactive to changes a client may make as a result of counseling.

Code of Ethics
As a Licensed Marriage and Family Therapist, I am governed by the Texas Code of Ethics for Licensed Marriage and Family Therapists. Copies of this Code are available upon request.

Appointments
Sessions are typically held once a week for 50-60 minutes. In the event that you will be unable to keep an appointment, please notify me at least 24 hours in advance. Clients are subject to being charged their full session fee for missed appointments without such notice. Late afternoon and evening appointments are considered high demand scheduling times. After one non-emergency cancellation or missed appointment (with less than 24 hour notice) scheduled during these high demand times, the client will only be offered appointment times outside the high demand times from that point on. If this is will not fit with their needs, I would be glad to refer to another counselor.

Phone calls are the preferred method of communication with my clients and will always be returned in a timely manner. E-mail may or may not be responded to as promptly. I cannot and do not receive text messages on my business line. If you need to cancel an appointment, please contact me directly by phone—especially for appointments that are less than 24 hour notice.

Termination
Ideally, termination of the counseling relationship is mutually agreed upon by the client and counselor. My desire for my clients is that they be content with their direction in life or toward a solution, and relatively confident in their skills and abilities to accomplish it.
Termination of the counseling relationship will automatically occur if there has been no contact between client and therapist for three (3) weeks.

Referrals
I believe that everyone has the right to participate in their treatment planning and that joint goal setting is the preferred professional relationship between client and therapist. If, for any reason, I am unable to meet a client's needs, I will gladly refer to other qualified practitioners

in the area. I encourage clients to inform me if any discomforts arise, so that we can work towards a resolution together.

Complaints
Complaints regarding this office should be directed to: the Texas State Board of examiners of Marriage and Family Therapists at 1-800-942-5540 or Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369

Fees
My fee is $90 per 50-60 minute session. My preferred methods of payment are cash or check (**made out to Carrie Austin**) at the time of the counseling appointment. I also take credit debit cards but there is a 2.75% fee for this method of payment. In the case of a returned check, there is a $30 returned check fee and all additional payments will need to be made in cash. Client initiated telephone consultations and/or therapy are eligible for billing at the regular hourly rate.

Emergencies
In the case of an emergency during business hours, the client can call me at (512) 870-8331 and if necessary leave a message. I will return their call as soon as possible. For emergencies after business hours, the client should call 911 or go to the nearest emergency room. Clients may also call the Crisis Hotline (472-4357), which provides telephone counseling, information, and referrals on a 24-hours basis.

Informed Consent

I acknowledge that I have read, fully understand, and received a copy of the information sheet citing the procedures and policies of Carrie Austin, MA, MA, LMFT. I understand this information is also available online at Mrs. Austin's website, www.caustincounseling.com.

This consent is for:

Parent 1 Name_____

Parent 1 Signature _____ Date _____

Parent 2 Name_____

Parent 2 Signature _____ Date _____

This consent is also for treatment for the following children (Full Names and ages) :

_____

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, healthcare surrogate, etc.)

_____

Relationship to client(s)

Carrie Austin, MA, MA, LMFT
(512)870-8331

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.

I will use the information about your health which I get from you or from others mainly to provide you with **treatment**, to arrange **payment** for services, and for some other business activities which are called, in the law, health care **operations.**

Disclosure (send, share, release) of any of your information for any other purposes will be discussed with you and you will be asked to sign an Authorization form to allow this.

I will, of course, keep your mental health information private but there are times when the laws require me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these that may apply, however, they do not occur very often. They are described in the longer version of the NPP that is available to you upon request.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. **Right to Request Confidential Communication**. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. I will try my best to do as you ask.
2. **Right to Request Restrictions**. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. **Right to Access to Inspect and Copy**. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you a reasonable fee for this. I will respond to requests in a timely manner, without delay for legal review, in less than 15 days if submitted in writing. I may deny access to any portion of a record (in accordance with the Texas Health & Safety Code 611.0045 (b)) if I determine that release of that portion would be harmful to a client's physical, mental, or emotional health.
4. **Right to Amend**. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information, although I am not required to agree to the amendment. You have to make this request in writing and tell me the reasons you want to make the changes.
5. **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you reasonable fees if you request more than one accounting in any 12 month period.
6. **Right to file a complaint**. If you believe your privacy rights have been violated. You can file a complaint with the Texas State Board of examiners of Marriage and Family Therapists at 1-800-942-5540 or Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369. All complaints should be in writing.

If you have any questions regarding this notice or our health information privacy policies, please contact Carrie Austin at 512-870-8331. *The effective date of this notice is January 1, 2014.*

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices of my privacy rights, I can contact Carrie Austin, MA, MA, LMFT at (512)870-8331.

Parent 1 Name_____

Parent 1 Signature _____ Date _____

Parent 2 Name_____

Parent 2 Signature _____ Date _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices of my privacy rights, I can contact Carrie Austin, MA, MA, LMFT at (512)870-8331.

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Relationship to client(s)