

Date: \_\_\_\_\_

**Minor Intake Form**

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred client? \_\_\_\_\_ Why did they refer client? \_\_\_\_\_

Why did you choose WTCG over other options? \_\_\_\_\_

What would you like to see happen as a result of counseling? \_\_\_\_\_

Did something happen to prompt you to seek help now, versus when the problem first began? \_\_\_\_\_

Is there pending / expected court involvement: custody, placement, parental rights, CPS?  Y  N

Is the client seeking disability due to their current mental/emotional health?  Y  N

Is the client seeking counseling due to a court order or criminal charges?  Y  N

**Client Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Parent/Guardian's Cell phone \_\_\_\_\_ Email \_\_\_\_\_

May we:  Call  Leave a message  Text  None

Prefer:  Cell  Home

**Gender**

- Male
- Female
- Non-binary/3<sup>rd</sup> gender
- Prefer to self-describe

---

- Prefer not to say

**Sexual Orientation**

- Straight/Heterosexual
- Gay, Lesbian, or Queer
- Bisexual
- Prefer to self-describe

---

- Prefer not to say

**Do you identify as transgender?**

- Yes
- No
- Prefer not to say

**Relationship status:**  Single  Significant other  Cohabiting  Engaged  Married  
 Separated  Divorced  Widowed

If married, how long? \_\_\_\_\_ If divorced/widowed, when? \_\_\_\_\_

**Racial/Ethnic identity:**  African American  Asian American  Hispanic/Latino  Native American  
 Pacific Islander  White/Caucasian  Other \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Contact number \_\_\_\_\_

Relationship to the client \_\_\_\_\_

**Military dependent?**  Y  N

**Education:** Current grade \_\_\_\_\_ School \_\_\_\_\_ Problems at school?  Y  N

If yes, please explain \_\_\_\_\_

What services does child receive from school? \_\_\_\_\_

**Employment:**  Full-Time  Part-Time  Student

Employer \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

**Family**

Parents:  Married  Cohabiting  Never Married  Separated  Divorced

Mother \_\_\_\_\_  Full Custody  Joint Custody  No Rights  Other

Father \_\_\_\_\_  Full Custody  Joint Custody  No Rights  Other

If other, please explain: \_\_\_\_\_

Is there a legal document outlining custody?  Y  N (**copy required prior to client being seen**)

Is the minor in the care of a guardian or conservator?  Y  N If yes, who? \_\_\_\_\_

What is this person's relationship to the child? \_\_\_\_\_

Is there a legal document detailing this?  Y  N (**copy required prior to client being seen**)

Siblings: How many? \_\_\_\_\_ I am the:  Oldest  In the Middle  Youngest  Only Child

Sibling Ages \_\_\_\_\_

List everyone living in the home with the client (name & relationship) \_\_\_\_\_

What are the most significant events in clients' life? \_\_\_\_\_

Has the client or anyone in the client's family experienced abuse or neglect?  Y  N

Is the client currently experiencing abuse or neglect?  Y  N

Is there a history of CPS involvement?  Y  N If yes, please explain \_\_\_\_\_

Religion/Denominational preference \_\_\_\_\_ Congregation (if any) \_\_\_\_\_

**Check all that the client is experiencing**

<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Rage
<input type="checkbox"/> Thoughts of death	<input type="checkbox"/> Excessive worry	<input type="checkbox"/> Anger
<input type="checkbox"/> Plans to harm self	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Irritability
<input type="checkbox"/> Thoughts of harming others	<input type="checkbox"/> Chronic fear	<input type="checkbox"/> Relationship to significant other
<input type="checkbox"/> Plans to harming others	<input type="checkbox"/> Irrational fears	<input type="checkbox"/> Relationship to parents
<input type="checkbox"/> Self-injury	<input type="checkbox"/> Problems due to abuse/trauma	<input type="checkbox"/> Relationship to children
<input type="checkbox"/> Loss of meaning in life	<input type="checkbox"/> Stress	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Loss of hope	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Sexual orientation
<input type="checkbox"/> Depression	<input type="checkbox"/> compulsions	<input type="checkbox"/> Gender identity issues
<input type="checkbox"/> Decreased pleasure	<input type="checkbox"/> Phobias	<input type="checkbox"/> Conflicts at work
<input type="checkbox"/> Lack of activities	<input type="checkbox"/> Feel like I'm losing control	<input type="checkbox"/> Problems in school
<input type="checkbox"/> Isolating/withdrawn	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Loss of faith in God
<input type="checkbox"/> Decreased energy/fatigue	<input type="checkbox"/> Muscle tension	<input type="checkbox"/> Religious doubts
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Problems with sleep	<input type="checkbox"/> Substance use problems
<input type="checkbox"/> Significant weight change	<input type="checkbox"/> Problems with concentration	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Feelings of worthlessness	<input type="checkbox"/> Problems with memory	<input type="checkbox"/> Delusions
<input type="checkbox"/> Grief	<input type="checkbox"/> Avoid open spaces	<input type="checkbox"/> Easily distracted
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Behavioral problems	<input type="checkbox"/> Other/Explain below
<input type="checkbox"/> Guilt feelings	<input type="checkbox"/> ADHD	

**What else is client experiencing at this time?** \_\_\_\_\_

**Mental Health**

Has the client experienced mental health problems before?  Y  N If yes, explain \_\_\_\_\_

Does the client have a family history of mental health problems?  Y  N

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

Y  N If yes, when and where? \_\_\_\_\_

Has the client ever been hospitalized or received inpatient treatment for mental health issues?  Y  N If yes, when and where? \_\_\_\_\_

**Self-Harm**

Has the client ever attempted suicide?  Y  N If yes, number of attempts \_\_\_\_\_

Has the client ever lost someone they care about to suicide?  Y  N

If yes, who and when? \_\_\_\_\_

**Substance Use History**

Does the client drink alcohol?  Y  N On average, how many drinks do you have? \_\_\_\_\_ per \_\_\_\_\_  
quantity & type day/week/month

Does the client use drugs (illegal drugs, recreational drugs, drugs not prescribed to client or used in excess of how they are prescribed)?  Y  N If yes, which ones? \_\_\_\_\_

How often? \_\_\_\_\_ per \_\_\_\_\_ IV drug use?  Y  N  
quantity & drug day/week/month

Has the client ever been treated (counseling, therapy, psychiatrist, medication) for a drug or alcohol problem?

Y  N If yes, when and where? \_\_\_\_\_

Completed successfully?  Y  N

Has the client ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

Y  N If yes, when and where? \_\_\_\_\_

\_\_\_\_\_ Completed successfully?  Y  N

**Medical History of Client**

Pediatrician \_\_\_\_\_ Date of last medical examination? \_\_\_\_\_

List any physical illness or symptoms the client is having at this time \_\_\_\_\_

List major surgeries or illnesses \_\_\_\_\_

List current medications (include dosages and physician prescribing) \_\_\_\_\_

** Custody or guardianship paperwork is required (if applicable) prior to a minor client being seen for services.**

**Acknowledgement**

The information written on this form is accurate, to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent / Guardian / Client

\_\_\_\_\_  
Date

***Appointment Reminder Preference***

Client Name: \_\_\_\_\_

West Texas Counseling & Guidance utilizes a contracted service to provide automated reminders of your next appointment 24 – 48 hours in advance as a courtesy reminder. Please choose a reminder option.

- Yes, I would appreciate a phone reminder. Please call me prior to my appointment at\_\_\_\_\_. I understand that if others have access to this number, confidentiality cannot be ensured.
- Yes, I would appreciate a text reminder. Please text me prior to my appointment at\_\_\_\_\_. I understand that if others have access to this number, confidentiality cannot be ensured.
- No, I would prefer not to be reminded of appointments and will keep up with them myself.

\_\_\_\_\_  
Signature of Parent / Guardian / Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Signature of WTCG Staff

\_\_\_\_\_  
Date

### ***No Shows and Cancellations***

Client Name: \_\_\_\_\_

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. If you fail to give 24 hours notice before cancelling their appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to make same-day appointments with your counselors. Clients may also be charged a **\$25 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than \$25 per session, the fee will be your usual session charge. Clients with certain insurances cannot be billed the missed appointment fee- Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

**Counselor Discretion:** The counselor may choose to continue to see the client without requiring same-day appointments. The counselor may also waive the \$25 fee.

**Weather Related:** Missed appointments due to dangerous weather will not count as a late cancellation.

**Due to the counselors maintaining a set schedule:**

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

*By signing this agreement I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.*

\_\_\_\_\_  
Signature of Parent / Guardian / Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Signature of WTCG Staff

\_\_\_\_\_  
Date

***Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices***

Client Name: \_\_\_\_\_

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction.

I am making an informed decision, free of any coercion, on behalf of the client to engage in psychotherapeutic/counseling/clinical social work services. It is my right to terminate these services at any point.

\_\_\_\_\_  
Signature of Parent / Guardian / Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Signature of WTCG Staff

\_\_\_\_\_  
Date





Date: \_\_\_\_\_

### Military Program Eligibility Form

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last 4 of SSN \_\_\_\_\_ Gender:  M  F Phone: \_\_\_\_\_

1. Has the client ever served in the U.S. Military?  Y  N (if *no*, skip to question 2)
  - a. **If yes**, what branch do/did you serve in?
    - Army
    - Air Force
    - Navy
    - Marine Corps
    - Coast Guard
  - b. What is your current military status?
    - Active duty
    - Retired
    - Prior service/inactive
    - Medically separated/retired
    - National Guard/Reserves
  - c. Dates of service: from \_\_\_\_\_ to \_\_\_\_\_
  - d. Client receives services from the V.A.  Y  N
  - e. Client has a service connected disability  Y  N Rating \_\_\_\_\_%
  - f. Client is a combat veteran  Y  N Name of operation/conflict: \_\_\_\_\_

2. Is the client a current dependent of a U.S. active duty or retired service member?  Y  N

3. Is the client related to any of the following who have ever served/or are currently in the U.S. military?  Y  N  
 Spouse  Fiancé  Boyfriend/girlfriend  Son/daughter  Sibling  Parent

**ⓘ If you answered no to 1-3, you do not have to continue this form.**

4. If you answered yes to either 2 or 3, please answer the following:

- a. Name of service member: \_\_\_\_\_
- b. What branch does/did they serve in?
  - Army
  - Air Force
  - Navy
  - Marine Corps
  - Coast Guard
- c. What is their current military status?
  - Active duty
  - Retired Prior service/inactive
  - Medically separated/retired
  - National Guard/Reserves
- d. Dates of service: from \_\_\_\_\_ to \_\_\_\_\_

In order to satisfy grant requirements, we need to verify eligibility via DD-214, ID, orders, or some other way to demonstrate military service.

**Eligibility of military or dependent status established by following documentation**

Each individual seeking services needs to verify eligibility as either a service member or a qualified family member. Please see example of documents below needed to verify eligibility. If individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding this program.

- military issued ID
- VA ID
- state issued veteran ID card (for the service member or a dependent)

All of the following require some form of photo ID

- DD 214
- birth certificate
- marriage certificate
- ID.me wallet- <https://www.id.me/>
- Signed statement by service member of familial relation

Other documents that can be used to verify military service (+ photo ID):

- orders of separation/retirement
- LES (Leave and Earning Statement)
- W2 reflecting military service
- orders of promotion
- orders of TDY (temporary duty)
- orders of PCS (Permanent Change of Station)
- orders to attend a military school
- orders of deployment
- citations from military awards, medals and decorations
- certificates of completion of a military school or operation
- DD form 4- Enlistment/Reenlistment Documents
- an award letter of benefits from the VA
- verification from a government program of the individual's veteran status
- military medical/dental records
- a sworn statement from veteran's military commander
- any other method likely to ensure legitimate eligibility of veteran or family member

① Individuals requesting services and claiming eligibility without written documentation of eligibility will be granted presumptive eligibility for a reasonable time of no longer than 30 days. This allows the veteran or family member to acquire the DD 214 (per the National Archives, 92% of requests for DD214 receive a response within 10 days), plus, additional time to obtain necessary documentation and other ID to establish eligibility. During the presumptive eligibility period, services provided will be those services and referrals necessary to assist the veteran or family member in establishing eligibility for services of the program, or other programs, as well as any indicated crisis services (services necessary to prevent injury from suicide, injury to others, substance use disorders, etc.).

- Copy of eligibility documents provided and included in chart by WTCG staff signing below**
- Eligibility documents visually verified by WTCG staff signing below**