Cindy Nelson, Ph.D., LPC

Welcome to my office. I am committed to providing you with quality care. Trust and openness are essential for effective therapy. Confidentiality is carefully protected. Matters discussed in therapy are not discussed with anyone without your permission. However, disclosure may be mandated in the following situations:

1. If there is risk of imminent serious harm to yourself or to others.
2. If your records are subpoenaed by a court of law.
3. If information is requested by your insurance company.
4. If you report neglect or abuse of a minor.
5. If you report sexual misconduct of a physician or therapist.

The business office is open Monday through Friday, 8:00 a.m. - 5:00 p.m. Additionally, appointments may be scheduled at other times. Please leave confidential messages on my voice mailbox (**972/380-4321**). Calls will be returned throughout the day.

The initial psychological evaluation is $175. Therapy sessions of 50 minutes are $160 per session. Payment is due at the time of the office visit. I will provide a receipt so that you can file for reimbursement with your insurance company.

If you are unable to keep a scheduled appointment, please leave a message on my voice mail 24 hours in advance to avoid being charged for the time reserved. Please provide a credit card/debit card number. This card will be charged if there is an outstanding balance on your account because of co-insurance or deductible or if there is a missed appointment without a 24 hour cancellation notice..

Card # _____ Expiration Date _____

V-Code_____ Billing Zip Code _____

Again, welcome to my practice. I look forward to working with you.
Cindy Nelson
Ph.D., LPC

I have read and understand the information about policies and services. I understand that I may have a copy for reference. I agree to be responsible for all charges for myself/spouse/children.

_____ _____
Signed Date

5055 W. Park Blvd., Suite 400, Plano, Texas 75093

Client Assessment Form

Date_____

Name_____

Address_____ **City**_____ **Zip**_____

Home Phone_____ **Work Phone**_____

Date of Birth_____ **Age** _____ **Sex** _____

Marital Status_____

Employer Name_____ **Work Number**_____

Spouse Name_____

Your Email address _____

CLIENT ASSESSMENT FORM

Effective treatment begins with an accurate assessment. Please answer the following questions as completely as possible. Feel free to write on the back or to add additional pages as necessary.

What is your chief concern at this time?

_____

_____

What stressful events have occurred recently?

_____

_____

_____

Please describe in detail the symptoms you have experienced

_____

_____

_____

When did these symptoms first begin?

_____

_____

Have you experienced similar symptoms before?(Please give time frame)

_____

_____

What have you tried that has made symptoms better?

_____

_____

What have you tried that has made symptoms worse?

_____

_____

Have you experienced any of the following recently? Please describe any "yes" answers.

_____ **Yes** _____ **No** **Consistently down or depressed mood most of the day, nearly every day.**

_____

_____

_____ **Yes** _____ **No** **Diminished level of interest or pleasure in most activities**

_____

_____

_____ Yes _____ No Change in appetite

_____

_____

_____Yes _____ No Change in weight

_____

_____

_____ Yes _____ No Feeling agitated or slowed down

_____

_____

_____ Yes _____ No Fatigue or loss of energy

_____

_____

_____ Yes _____ No Feelings of worthlessness or excessive guilt

_____

_____

_____ Yes _____ No Difficulty thinking or concentrating

_____

_____

_____ Yes _____ No Change in sex drive

_____

_____

_____ Yes _____ No Irritability, rage or violent behavior

_____

_____ Yes _____ No Hyperventilation, heart palpitations, intense fear

_____

_____

_____Yes _____ No Change in drinking/drug use patterns

_____

_____

_____ Yes _____ No Thoughts of death or suicide

_____

_____ **Yes** _____ **No** **Access to handgun, rifle, shotgun, etc.**

_____

_____

Any prior therapy? (Please list dates, issues addressed)

_____

_____

_____

Have you taken psychiatric medications for depression, anxiety, insomnia, etc?

_____

_____

_____

Have you ever attempted suicide?

_____

_____

It is important to give honest estimates of your intake of the following:
Nicotine _____ **packs per day** _____ **years of smoking**
Caffeine _____ **average daily intake of coffee, tea, cola drinks**
Alcohol _____ **average daily consumption**

Other drug use (please circle) **marijuana, cocaine, amphetamines, LSD, heroin, mushrooms, ecstacy, inhalants, prescription narcotics, other** _____

_____ **Yes** _____ **No** **Any history of food binging**
_____ **Yes** _____ **No** (Please circle) **Any use of laxatives, diuretics, diet pills, purging or food restriction for weight control**
_____ **Yes** _____ **No** (For women) **Other than during pregnancy, have you ever missed 3 or more periods**

Have you experienced significant physical, sexual, or emotional trauma? _____

_____

To whom have you disclosed these experiences?_____

Personal physician and phone number:_____
Date of most recent exam: _____
Please list major medical problems you have experienced (heart disease, diabetes, thyroid disease, etc.)

_____

_____

Any prior surgeries? (Give date, reason, complications) _____

_____

Hospitalizations? _____

List <u>ALL</u> medications you currently take or have recently taken? (Give name, dosage and duration of medication usage). _____

_____

Research has shown that heredity is important in many psychiatric disorders. Please take the time to think of various blood relatives who may have had similar symptoms to yours. Also note if any had problems with depression, anxiety, bi-polar disorder, eating disorders, alcohol or drug dependency, phobias, or suicidal behavior.

RELATIVE **PROBLEM**

_____

_____

_____

_____

Home Town _____ **Length of time in local area** _____

Describe your parent's relationship_____

_____

Describe your mother (note strengths and weaknesses)_____

_____

Describe your father (note strengths and weaknesses) _____

_____

Describe your siblings (list according to name and age) _____

_____

_____

Describe your childhood _____

_____

_____

_____

Describe your current relationship with your family _____

_____

List marriages or other long term relationships (give duration and describe relationship)

Describe your children (list according to name and age)

Level of education _____ **Major** _____
School _____ **Graduation date** _____
Occupation _____ **Length of employment** _____

What are your greatest achievements? _____

What was your greatest disappointment? _____

How often are you able to cry/express sadness? _____
How often are you safely able to express resentment or anger? _____
How often do you journal about private thoughts/feelings? _____
Please describe your support network (those in whom you confide and/or feel supported by)

Client Signature _____ **Date** _____

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972-380-4321

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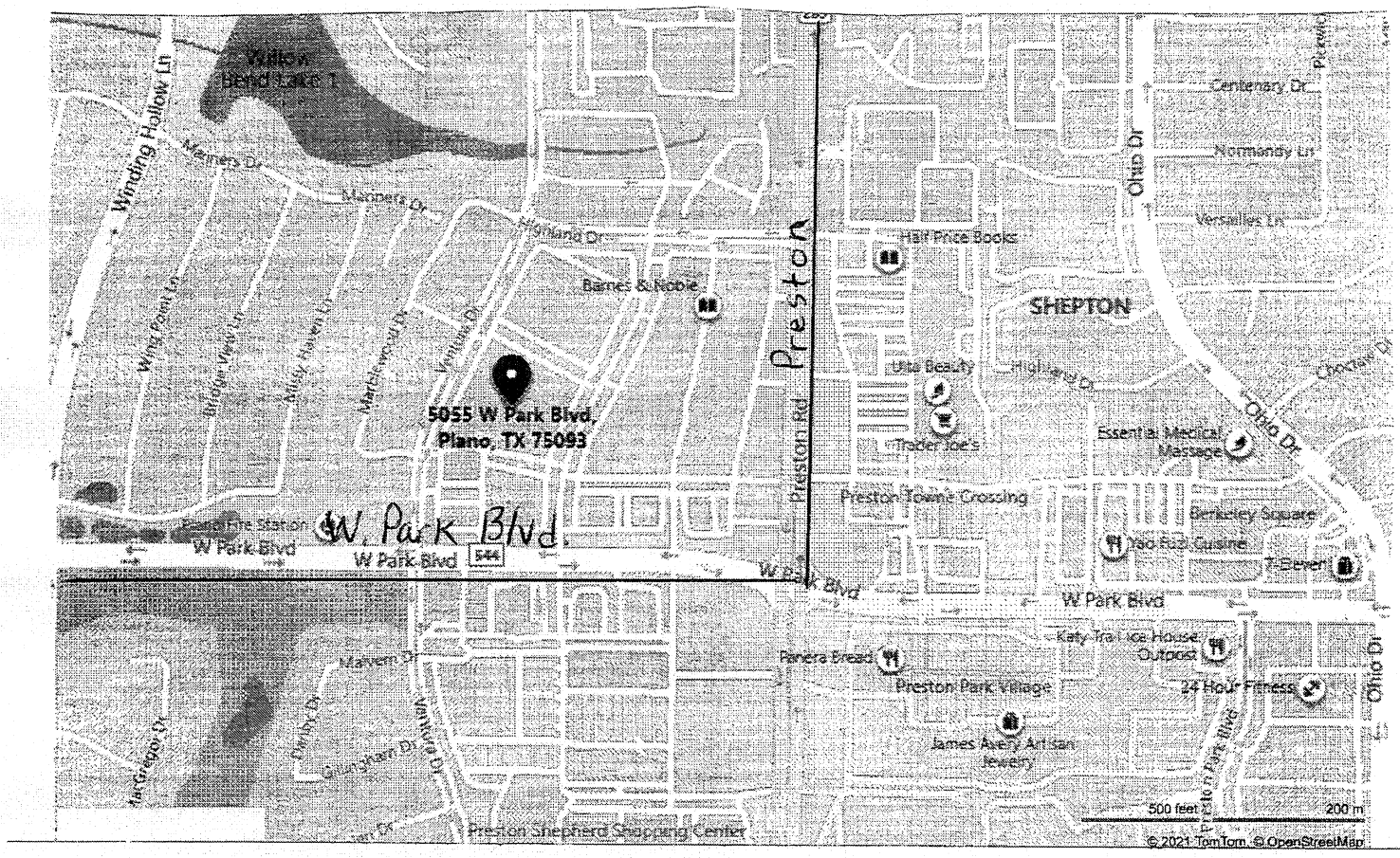
Suite 400
Plano, Tx. 75093



Our office, Park Ventura, is at **5055 W. Park Blvd., Suite 400**.
We are northwest (NW) of the intersection of Preston Rd. and W. Park Blvd.

From Preston Rd. turn west. Drive to Veritex Bank at the corner of Park and Ventura. Turn right (north) on Ventura. Drive to the second turn-in to the parking lot. Turn in to the right. The office is a one story reddish brick building with the number 400 at the entrance.