

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 mail (972/380-4321). Calls will be returned throughout the day.

The initial psychological evaluation is \$135. Therapy sessions of 50 minutes are \$120 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

5068 W. Plano Parkway, Suite 196, Plano, Texas 75093

Client Assessment Form

Date _____

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Age _____ Sex _____

Marital Status _____ Social Security Number _____

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** **Change in sleep pattern**

_____ **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, ecstasy, inhalants, prescription narcotics, other _____

Height _____ **Weight** _____

_____ **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 ALL 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? _____

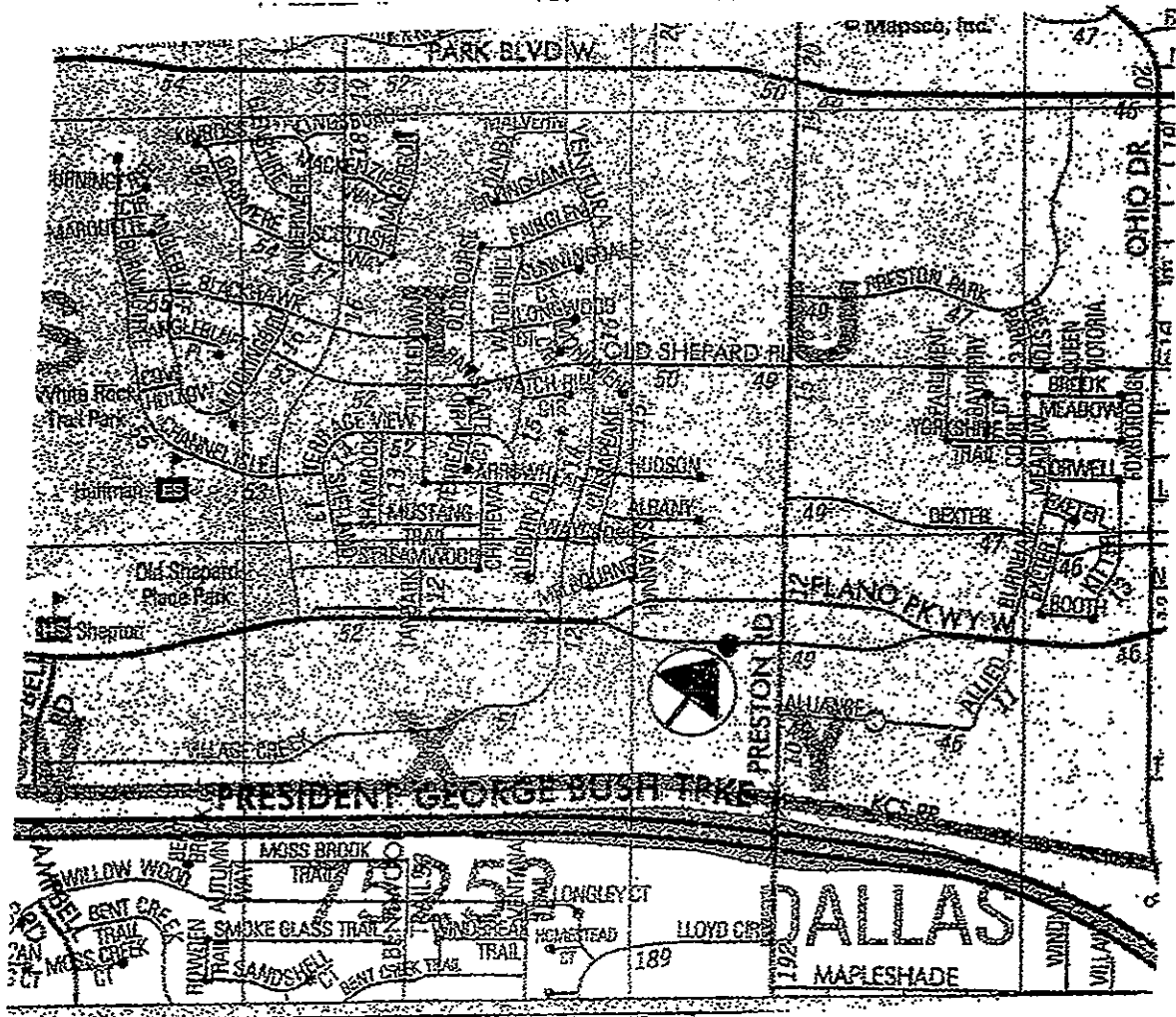
How often are you safely able to express resentment or anger? _____

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** _____

5068 W. Plano Parkway, Suite 196
Plano, Tx. 75093



Our office is just west of Preston Road on the south (eastbound) side of West Plano Parkway. It is the 3 story gray glass building, Parkway Commons, at 5068 W. Plano Parkway. We are behind (or west of) Park Place Lexus. When you enter the building, turn left and follow the hallway to Suite 196. It will be on the right.

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