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 $165. Therapy sessions of 50 minutes are $150 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** **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, 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 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** ______________________

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972-380-4321

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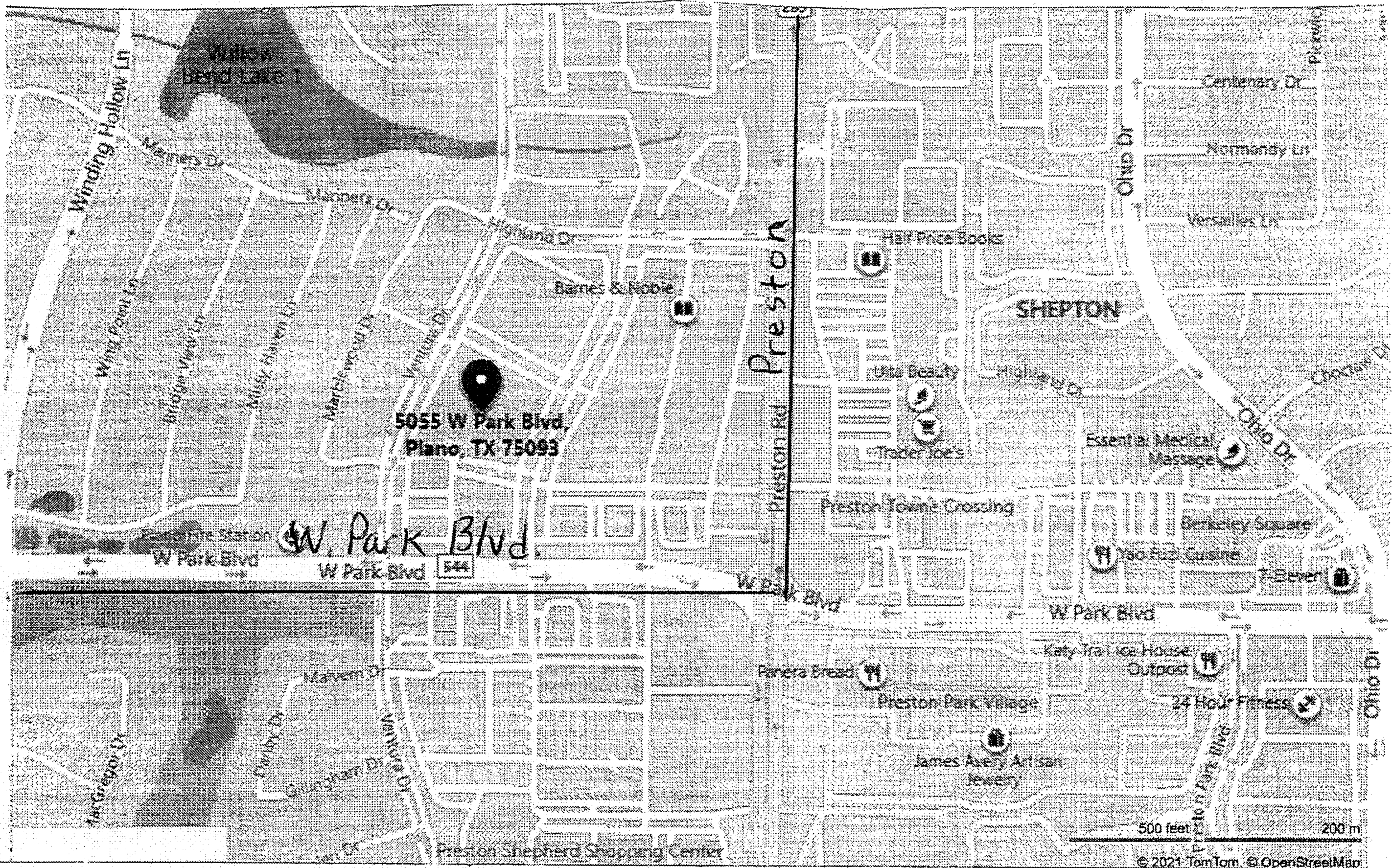
Plano, Tx. 75093



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.