



**Personal Information**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Male \_\_ Female \_\_ Minor \_\_ Single \_\_ Married \_\_ Divorced \_\_ Separated \_\_ Widowed \_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: Yellow Pages; Insurance Company; Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Where would you like us to leave reminder messages: Home \_\_; Work \_\_; Cell Phone \_\_; Email \_\_; None \_\_

If there is emergency at the office and we must cancel the appointment, where should we call:

\_\_\_\_\_

In the event of an emergency with you, whom should we contact: Name:

\_\_\_\_\_

Relationship: \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

**Who is responsible for this account?**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

**Authorization and Release:**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Anisha Shah, M.A., L.P.C. the right to seek the services of a bill-collecting agency in efforts to collect fees that I have not paid to her for services rendered and/or for cancelled or missed appointments.

Any outstanding balance may be charged to my credit card.  VISA  MC

Card Number \_\_\_\_\_ Expiration Date: \_\_\_\_\_

X \_\_\_\_\_  
Signature of patient or parent if minor \_\_\_\_\_ Date

**About Your Child's Education**

Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Nick Names: \_\_\_\_\_ Failure or Held Back? \_\_\_\_\_

What do school personnel tell you about your child? \_\_\_\_\_

Grade	<u>School</u>	<u>Average Gr</u>	City	State
<b><u>Pre-K</u></b>				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

**About Your Child's Family**

Relatives	Name	Age/Grade	Does Child Get Along Well with this Person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step Mother				
Step Sister(s)				
Step Brother(s)				
List all people who live in the home with this child:				

**About Your Child's Routine**

What kinds of physical exercise does your child get? \_\_\_\_\_

How much coffee, cola, tea, or other caffeine does your child consume each day \_\_\_\_\_

Is your child's eating restricted in any way? How? Why? \_\_\_\_\_

Bedtime: \_\_\_\_\_ Wake-up Time: \_\_\_\_\_ Hours of sleep on an average night: \_\_\_\_\_

Does your child have any problems getting enough sleep? \_\_\_\_\_(Please describe fully.)

\_\_\_\_\_

**About Your Child's Health**

Who is your child's pediatrician? \_\_\_\_\_ When was the last visit? \_\_\_\_\_

Any Concerns shared by the doctor? \_\_\_\_\_

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

\_\_\_\_\_

\_\_\_\_\_

Describe any allergies your child has: \_\_\_\_\_

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please \_\_\_\_\_

List all prior counselors/dates/reasons: \_\_\_\_\_

Anything else you are concerned about? \_\_\_\_\_

**(These Questions are regarding older children)**

Is this child in a gang? \_\_\_\_\_ Has this child used drugs? \_\_\_\_\_. If so, describe which drugs, frequency, age at first use, and amounts \_\_\_\_\_

Has this child ever been pregnant or fathered a child? \_\_\_\_\_ If yes, please tell what happened with each pregnancy: \_\_\_\_\_

\_\_\_\_\_

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**Agreement for Therapy with a Minor:**

I, \_\_\_\_\_, the parent/legal guardian of the minor, \_\_\_\_\_,

- Give my permission for this minor to receive therapeutic services provided through Kirkland Clinical Associates.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.
- I also agree to allow counseling sessions to be audio and/or video taped in order for Anisha Shah to receive supervision toward licensure as a Professional Counselor.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

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Signature of parent/guardian

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Date

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## About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accident-prone                     | <input type="checkbox"/> Insults others                        | <input type="checkbox"/> Slow-moving                    |
| <input type="checkbox"/> Affectionate                       | <input type="checkbox"/> Interrupts                            | <input type="checkbox"/> Slow-responding                |
| <input type="checkbox"/> Aggressive                         | <input type="checkbox"/> Intimidated by others                 | <input type="checkbox"/> Smart-alecky                   |
| <input type="checkbox"/> Argues                             | <input type="checkbox"/> Intimidates others                    | <input type="checkbox"/> Smoking                        |
| <input type="checkbox"/> Assaults                           | <input type="checkbox"/> Intolerant                            | <input type="checkbox"/> Social                         |
| <input type="checkbox"/> Bathroom language                  | <input type="checkbox"/> Irritability                          | <input type="checkbox"/> Speech difficulties            |
| <input type="checkbox"/> Bigoted                            | <input type="checkbox"/> Isolates                              | <input type="checkbox"/> Stealing                       |
| <input type="checkbox"/> Bossy to others                    | <input type="checkbox"/> Lacks organization                    | <input type="checkbox"/> Stubborn                       |
| <input type="checkbox"/> Breaks rules                       | <input type="checkbox"/> Lacks respect for authority           | <input type="checkbox"/> Suicide talk or attempt        |
| <input type="checkbox"/> Breaks the law                     | <input type="checkbox"/> Learning disability                   | <input type="checkbox"/> Swearing                       |
| <input type="checkbox"/> Bullied by others                  | <input type="checkbox"/> Legal difficulties                    | <input type="checkbox"/> Talks back                     |
| <input type="checkbox"/> Bullies others                     | <input type="checkbox"/> Lethargic                             | <input type="checkbox"/> Talks out                      |
| <input type="checkbox"/> Cheats                             | <input type="checkbox"/> Likes to be alone                     | <input type="checkbox"/> Teased                         |
| <input type="checkbox"/> Clowns around                      | <input type="checkbox"/> Loitering                             | <input type="checkbox"/> Teases others                  |
| <input type="checkbox"/> Competition                        | <input type="checkbox"/> Loss of friends                       | <input type="checkbox"/> Temper tantrums                |
| <input type="checkbox"/> Complains                          | <input type="checkbox"/> Low frustration tolerance             | <input type="checkbox"/> Threatens                      |
| <input type="checkbox"/> Complains of feeling sick          | <input type="checkbox"/> Lying                                 | <input type="checkbox"/> Thumb sucking                  |
| <input type="checkbox"/> Compliant                          | <input type="checkbox"/> Manipulates                           | <input type="checkbox"/> Tics-movements or noises       |
| <input type="checkbox"/> Concern for others                 | <input type="checkbox"/> Masturbation                          | <input type="checkbox"/> Timid                          |
| <input type="checkbox"/> Conflicts at school                | <input type="checkbox"/> Mental retardation                    | <input type="checkbox"/> Truancy                        |
| <input type="checkbox"/> Conflicts at home                  | <input type="checkbox"/> Moody                                 | <input type="checkbox"/> Uncooperative                  |
| <input type="checkbox"/> Conflicts with friends             | <input type="checkbox"/> Mute, refuses to speak                | <input type="checkbox"/> Uncoordinated                  |
| <input type="checkbox"/> Conflicts with police              | <input type="checkbox"/> Nail biting                           | <input type="checkbox"/> Under-active                   |
| <input type="checkbox"/> Cries easily                       | <input type="checkbox"/> Name calling                          | <input type="checkbox"/> Unhappy                        |
| <input type="checkbox"/> Cruel to animals                   | <input type="checkbox"/> Needs for high degree of supervision  | <input type="checkbox"/> Unprepared                     |
| <input type="checkbox"/> Dares others                       | <input type="checkbox"/> Negativism                            | <input type="checkbox"/> Vandalism                      |
| <input type="checkbox"/> Dawdles                            | <input type="checkbox"/> Nervous                               | <input type="checkbox"/> Violent                        |
| <input type="checkbox"/> Daydreams                          | <input type="checkbox"/> New school                            | <input type="checkbox"/> Wastes time                    |
| <input type="checkbox"/> Defiant                            | <input type="checkbox"/> Nightmares                            | <input type="checkbox"/> Wetting/soiling of bed/clothes |
| <input type="checkbox"/> Dependent                          | <input type="checkbox"/> Noisy                                 | <input type="checkbox"/> Withdraws                      |
| <input type="checkbox"/> Destructive                        | <input type="checkbox"/> Noncompliant                          | <input type="checkbox"/> Work problems                  |
| <input type="checkbox"/> Developmental delay s              | <input type="checkbox"/> Obedient                              | <input type="checkbox"/> Yells                          |
| <input type="checkbox"/> Difficulties with parent's partner | <input type="checkbox"/> Obesity                               | <input type="checkbox"/> Any other characteristics:     |
| <input type="checkbox"/> Disobedient                        | <input type="checkbox"/> Only younger playmates                | _____   |
| <input type="checkbox"/> Disrupts family activities         | <input type="checkbox"/> Oppositional                          | _____   |
| <input type="checkbox"/> Distractible                       | <input type="checkbox"/> Outgoing                              | _____   |
| <input type="checkbox"/> Dropping out of school             | <input type="checkbox"/> Out-of-seat behaviors                 | _____   |
| <input type="checkbox"/> Drug or alcohol use                | <input type="checkbox"/> Overactive                            | _____   |
| <input type="checkbox"/> Drug sales                         | <input type="checkbox"/> Picks on others                       | _____   |
| <input type="checkbox"/> Eating Issues                      | <input type="checkbox"/> Poor concentration                    | _____   |
| <input type="checkbox"/> Failure in school                  | <input type="checkbox"/> Pouts                                 | _____   |
| <input type="checkbox"/> Fantasy life                       | <input type="checkbox"/> Prejudiced                            | _____   |
| <input type="checkbox"/> Fearful                            | <input type="checkbox"/> Procrastinates                        | _____   |
| <input type="checkbox"/> Feelings are easily hurt           | <input type="checkbox"/> Provokes others                       | _____   |
| <input type="checkbox"/> Fidgety                            | <input type="checkbox"/> Rages                                 | _____   |
| <input type="checkbox"/> Fighting                           | <input type="checkbox"/> Recent move                           | _____   |
| <input type="checkbox"/> Finger sucking                     | <input type="checkbox"/> Refuses                               | _____   |
| <input type="checkbox"/> Fire setting                       | <input type="checkbox"/> Relationships with friends            | _____   |
| <input type="checkbox"/> Friendly                           | <input type="checkbox"/> Relationships with siblings           | _____   |
| <input type="checkbox"/> Hair chewing                       | <input type="checkbox"/> Relationships with teachers           | _____   |
| <input type="checkbox"/> Head banging                       | <input type="checkbox"/> Resists                               | _____   |
| <input type="checkbox"/> Hitting                            | <input type="checkbox"/> Responsible                           | _____   |
| <input type="checkbox"/> Hostile                            | <input type="checkbox"/> Restless                              | _____   |
| <input type="checkbox"/> Hyperactive                        | <input type="checkbox"/> Rocking or other repetitive movements | _____   |
| <input type="checkbox"/> Hypochondriac                      | <input type="checkbox"/> Runs away                             |   |
| <input type="checkbox"/> Imaginary playmates                | <input type="checkbox"/> Sad                                   |   |
| <input type="checkbox"/> Immature                           | <input type="checkbox"/> School avoiding                       |   |
| <input type="checkbox"/> Inappropriate sexual behaviors     | <input type="checkbox"/> Self-harming behaviors                |   |
| <input type="checkbox"/> Inattentive                        | <input type="checkbox"/> Sexual preoccupation                  |   |
| <input type="checkbox"/> Independent                        | <input type="checkbox"/> Sexually active                       |   |
| <input type="checkbox"/> Inflicts pain on others            | <input type="checkbox"/> Shy                                   |   |

## **ABOUT ANISHA SHAH MA, LPC**

Please Initial Each Paragraph:

I understand that Anisha Shah is a Licensed Professional Counselor in the state of Texas and holds a B.S. in Childhood Education, and a M.S. in Human Development. She also holds an M.A. in Clinical/Counseling Psychology from Southern Methodist University, Dallas, Texas.

I understand that Anisha Shah works with children, adolescents, and adults in individual, group, and family counseling.

I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Anisha Shah about this.

I understand that Anisha Shah does not perform formal testing but refers individuals to those who do.

I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Anisha Shah to tell someone else in writing or verbally, b) Anisha Shah determines that her client poses a threat to them self or others, c) She is ordered by a court to disclose information, or d) She suspects that child abuse has taken place, at which time he will notify Child Protective Services.

I understand that counseling can improve as well as upset the equilibrium in any person or family.

I understand that if I have a complaint I cannot resolve with Anisha Shah and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Anisha Shah.

I understand that there is a returned check fee of \$25.00 and that if a returned check is not cleared up in 30 days Anisha Shah will file a suit with the Dallas County District Attorney's Office.

I understand that all co-pays are due at the time of service.

I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of \$60.00.

I understand that the rate for an initial session is \$125.00 and for subsequent sessions is \$125.00. These fees are for 45-minute sessions.

I understand that Anisha Shah is not a psychiatrist, she is a Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.

***By signing below I confirm that I have read, agree to and received the above information:***

---

*Client/Parent of Client Date Received and Read*

**This copy is for you to read, sign, and leave with Anisha Shah**

## ABOUT ANISHA SHAH MA, LPC

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***By signing below I confirm that I have read, agree to and received the above information:***

---

*Client/Parent of Client Date Received and Read*

**This copy is for you to read, sign, and keep for your records**

# Notice of Privacy Practices

**Kirkland Clinical Associates  
Richardson, Texas**

*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.*

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

**You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services. You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003.**

**THIS IS YOUR COPY TO KEEP**

**Acknowledgement of Receipt Of Notice of Privacy Practices**  
**For**  
**Kirkland Clinical Associates**

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If patient is a minor, Parent or guardian must sign)

**Consent For use and Disclosure of Health Information**

I hereby permit Kirkland Clinical Associates to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

**Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_**  
**(Parent or Guardian if Patient is a Minor)**

**You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.**

Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on our website at [WWW.DanKirkland.com](http://WWW.DanKirkland.com) and in a notebook in the waiting room. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.