

# INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

- Never Married  Domestic Partnership  Married  
 Separated  Divorced  Widowed

Please list any children/age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) May we leave a message?  Yes  No

Cell/Other Phone: ( ) May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): \_\_\_\_\_

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No  
 Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

- Yes
- No

Please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates: \_\_\_\_\_

\_\_\_\_\_

#### GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good

Please list any specific health problems you are currently experiencing:

\_\_\_\_\_

2. How would you rate your current sleeping habits? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good

Please list any specific sleep problems you are currently experiencing:

\_\_\_\_\_

3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in? \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns:

\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief, or depression?

- No
- Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe: \_\_\_\_\_

8. Do you drink alcohol more than once a week?  No  Yes

9. How often do you engage recreational drug use?  
 Daily  Weekly  Monthly  Infrequently  Never

10. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

11. What significant life changes or stressful events have you experienced recently:

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**FAMILY MENTAL HEALTH HISTORY:**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed?       No       Yes

If yes, what is your current employment situation?

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Do you enjoy your work? Is there anything stressful about your current work?

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2. Do you consider yourself to be spiritual or religious?       No       Yes

If yes, describe your faith or belief:

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3. What do you consider to be some of your strengths?

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4. What do you consider to be some of your weaknesses?

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5. What would you like to accomplish out of your time in therapy?

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# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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## **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

## **Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

## **Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

## **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

## **Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

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Client Signature (Client's Parent/Guardian if under 18)

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Today's Date

## CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

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Client Signature (Client's Parent/Guardian if under 18)

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Today's Date

**Professional Fee Schedule and Policies**

**Payment Policies:**

Payment for professional services is due at the time of each appointment, unless other arrangements have been discussed directly with me. You may pay with check, cash or credit card. Each session is 60 minutes long. Please note that if you are late in arriving, your session time starts at the scheduled time, not at the time you arrive.

If you are unable to make your scheduled appointment due to illness or other emergency situations, please call to reschedule your appointment. Should you not call to cancel or reschedule, you are responsible for that missed session fee as this time has been reserved for you. Should you be using your insurance, please be aware that you, not your insurance company, are responsible for the missed session fee. Insurance companies will not pay for these charges. Under usual circumstances, 24 hour notification is required. Monday appointments must be canceled on Friday. I appreciate your cooperation in this matter as there often are others who are waiting to be notified if a time becomes available. This courtesy also eliminates any possibility of misunderstandings or feelings which can interfere with your commitment to yourself in therapy.

If you choose to use your insurance for paying part of your professional fees, please be aware that I am an ***out-of-network provider***, which means I do not participate in any insurance panels including HMO's; this will have an effect on your co-payment and/or your deductible. Fees for professional services are due at the time of each session. I will submit insurance claims at month's end for you, and you are directly reimbursed by the insurance company. One of the benefits of working with an-out-of network-provider is the increased flexibility for extended sessions as well as a full 60 minute session versus the insurance standard of 45 minutes. *You are responsible for contacting your insurance provider to determine your mental health benefits, co-pays, deductibles, etc. Please do this prior to our first appointment so that you are fully informed about your participation in your growth and healing. I appreciate your effort.*

Please be aware that in the highly unlikely event of a returned check by your bank, a \$35.00 fee will be charged to you.

**Professional Fee Schedule:**

Initial session, 90 minute session.....	\$250.00
Individual Psychotherapy, 60 minute session.....	\$130.00
Extended Sessions, each 15 minute segment.....	\$ 32.00
Family, couples session, 90 minute .....	\$200.00
Extended Sessions, each 15 minute segment.....	\$ 35.00
Written reports for Court, Mediators, other Professionals (per hour, 1 hour min.)...	\$130.00
Conferences with schools, other Professionals (per half-hour, half-hour min.).....	\$ 65.00
(travel-time added)	

Please do not hesitate to discuss any questions regarding payment with me, as payment is part of our therapeutic contract.

I have read these policies and agree to these terms.

\_\_\_\_\_  
Client signature (parent's signature if client is a minor)

Date \_\_\_\_\_

Medical History: Please list any surgeries, hospitalizations, injuries with appropriate explanations, including dates and your age at the time.

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Please use the back of this sheet for additional space, if needed.

Please tell me about any significant losses, changes, trauma (i.e. deaths, divorce in family, events you remember growing up) in your life, including dates and your age at the time.

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## **Informed Consent to Treatment**

The majority of individuals who participate in therapy benefit from the process. What you may want to achieve or change varies depending on the particular situation being addressed. Therapy requires a very active effort on your part. Self-exploration, gaining knowledge, finding ways for dealing with problems and learning new skills are part of the process and are generally quite useful. Some risks do exist, however.

While the benefits of therapy are well known, you may experience feelings which are more intense, different or entirely new to you: unhappiness, anger, guilt, frustration, for example. These are a natural part of the therapy process and can provide the basis of change. Important personal decisions are often a result of therapy. These decisions, including changing behavior, exploring life changes, substance abuse patterns, schooling, or relationships, are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member may be viewed quite negatively by another family member, and may initiate a whole process of change.

Initial impressions about treatment plans, based on collaborative goals and objectives will be discussed in the initial stage of therapy. Your own feelings about your comfort with your therapist are an important part of the collaborative effort, and should be discussed along with other issues with your therapist. If you have questions about the services being provided at any time during the course of therapy, you may ask for clarification.

**Confidentiality:** Anything discussed in therapy is confidential and cannot be disclosed to anyone without your written permission. There are, however, exceptions: 1. I keep written notes about what occurs in session. These records may be subpoenaed under certain conditions and we may be obligated by a Judge to surrender them. 2. If you report to me that you are the perpetrator or victim of child abuse or molestation, I am obligated to report this to the appropriate agencies. 3. If you indicate that you intend to hurt yourself or someone else, I must act to notify potential helpers or victims. 4. If you are a minor, your parents or guardians will be informed of your progress, if they ask. However, I do not discuss details of our conversations.

**Emergencies:** Should a crisis occur, you may call to request an extra appointment. If you have an immediate need and cannot wait for an appointment, please call the Crisis Hotline: 1-800-479-3339.

**Therapeutic Relationship:** You may call outside of session, should the need arise, for short consultations. I am in my office Monday-Thursday for appointments. Fridays are reserved for meetings and professional development. When I am out of town, you may be given the name and number of the on-call therapist. Depending on availability. The on-call therapist will not have details of your therapy, but is there for additional support until I am back in the office.

**Consultation:** Consultation with another mental or allied health professional may be of benefit for a comprehensive treatment approach. Your written permission is required prior to any consultation where you are identified or recognizable.

**Termination of therapy:** You have the right at any time to end therapy; however, should this occur, you and I will arrange a closure sessions for a good ending. I will help you secure an appropriate referral to another mental health professional whenever it is requested.

**Fee increases:** In order to keep abreast with cost-of-living changes, every few years I may increase my fees, usually about 10%. You will be notified of any such increases in a timely manner and we will address this matter.

I have read and understand about the benefits and risks of therapy, and I hereby give my consent to this psychological treatment.

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Client Signature (or Parent /Guardian if client is a minor)

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Date

## **Amendment to Informed Consent The Patriot Act of 2001**

Section 215 of the Patriot Act of 2001 contains a troublesome exception to confidentiality in that it not only requires therapists (and others) to provide Federal Bureau of Investigation (FBI) agents with books, records, papers, documents, and other items (Art Therapy products), but it also then prohibits the therapist from disclosing to the client that the FBI agent sought or obtained the items under the Act.

In 1978, Congress, through the Foreign Intelligence Surveillance Act (FISA), created the Foreign Intelligence Surveillance Court (FISC) to supervise FBI surveillance in foreign intelligence investigations. The FISC hears FBI applications for orders and warrants, including Section 215 orders. Under FISA, the FBI was required to make an application to the FISA Court for an order requiring documents for an investigation to protect against international terrorism or clandestine intelligence activities. Unfortunately, the FISA Court meets in secret, rarely published its decisions and allows only the government to appear before it. Section 215 of the Patriot Act amends FISA in several ways, and creates an ethical quandary for therapists in that those who are ordered to turn over records or other "tangible things" are prohibited from mentioning to anyone else that the FBI sought the information.

In another circumstance, a therapist faced with a subpoena for client records, for example, would first contact the client to determine whether the psychotherapist-patient privilege is being asserted or waived. However, such an option is not available under the Patriot Act. A therapist faced with a Section 215 order would be in violation of federal law, and possibly subject to legal action, if he/she disclosed to anyone that the FBI has sought or obtained what would otherwise be confidential client information. Clearly, such a situation would interfere with the therapeutic alliance. Third-party interference in the therapeutic relationship would normally be addressed in treatment. However, a therapist who has complied with a Section 215 order may find him/herself in a conflicted role, unable to process the very nature of the conflict to anyone, especially the client. One could argue that such a circumstance would create an unethical dual relationship, or other conflict of interest, which may require the therapist to prematurely terminate treatment, without the ability to process the reasons for the termination with the client.

Therapists are not alone in their concerns about Section 215 orders. Any person or entity can be served with a Section 215 order. However, therapists have unique relationships with their clients, which may be permanently damaged by gag provisions of the Act. If you are concerned about the implications of the Patriot Act, contact your Congressman to express your concerns, or the American Civil Liberties Union (ACLU) at [www.aclu.org](http://www.aclu.org) to find out what you can do to help.

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Client signature

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Date