

Client Intake

Date: _____ **Referred By:** _____

Interested In: _____ Individual Counseling _____ Couples Counseling _____ Group Counseling
_____ Support Group _____ Mentoring _____ Workshops _____ Other

Name: _____ **Phone #:** _____

Address: _____

Email: _____

Date of Birth: _____ **Age:** _____

Marital Status: Single/Never Married Single/Widowed Married Separated Divorced

Number in Household: _____ List Household Members *Can continue on back if needed

Name: _____ **DOB:** _____ **Relationship:** _____

Household Monthly Income: _____ **Insurance Info:** _____

Reason for seeking counseling: _____

Previous Counseling Experience? Include name of counselor and dates of therapy below:

Legal Involvement (Attorneys, Courts, CPS, etc.): YES _____ NO _____ If YES, please list:

Name: _____ **Phone #:** _____

Demographic Information (Optional): *Used for grant proposals, donor reports, and determining service to offer

Age Range: 12-17 18-25 26-34 35-44 45-54 55-64 65+

Race/Ethnicity: Middle Eastern/Northern African Black/African American Asian
Hispanic/Latino American Indian/Alaska Native Native Hawaiian/Pacific Islander White

Are you currently under medical treatment? YES or NO If YES, Doctor Name: _____

Please Describe any significant current or chronic diagnosed medical conditions: _____

Are you currently taking any medication? YES or NO If YES, list name & dosage: _____

Previous medications taken (include dates): _____

Any allergies? Especially if drug related: _____

Do you have any physical complaints at this time? _____

Is there any history of mental illness in your family? YES or NO If YES, please describe: _____

Circle the appropriate answer:

I drink alcohol:	Never	Seldom	Socially	To Excess
My spouse drinks alcohol:	Never	Seldom	Socially	To Excess

Is anyone in your family, past, or present, an alcoholic/problem drinker? YES or NO If YES,

Explain: _____

Briefly describe any history of drug or alcohol abuse: _____

Are you struggling with any habit that causes you to feel out of control? YES or NO If YES,

Explain: _____

Have you ever had any suicidal thoughts? Attempts? YES or NO If YES, Explain: _____

Are you experiencing any changes in eating? YES or NO If YES, Explain: _____

Are you experiencing any changes in sexual activity? YES or NO If YES, Explain: _____

Are you experiencing any changes in sleep? YES or NO If YES, Explain: _____

Describe three of the most traumatic experiences in your life & how you were impacted:

1. _____

2. _____

3. _____

Give a brief history of your relationship with your:

Father: _____

Mother: _____

Sibling: _____

Spouse/Partner: _____

Spirituality:

Describe your religious or spiritual affliction or orientation: _____

Do you regularly attend church? _____

Name of Church: _____

Are there any additional comments you would like to tell me about yourself? _____

Informed Consent

What can I expect from counseling? It is my desire that your counseling experience be a time of personal growth for you. The benefit from your therapy may be that you will be better able to cope with or handle your family and other social relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person. However, you should be aware that psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of guilt, anxiety, depression, loneliness, or helplessness may also be aroused.

Confidentiality: As a person in counseling, you have certain rights of which you should be aware. They are as follows:

1. You have the right to decide not to receive psychotherapy from me, or to end therapy at any time without any moral or legal obligations.
2. You have the right to ask any questions about the procedures or techniques used during therapy and to prevent the use of certain therapeutic techniques if you are not comfortable with them.
3. One of your most important rights involves confidentiality. No information, including the fact that you are in therapy or any particular appointment time, will be released without your written consent, within certain limits. Those limits are imposed by law and are as follows:

- If you threaten grave bodily harm or death to another person, I must inform the person and the appropriate law agency.
- If a court of law issues a legitimate subpoena I must provide the information specifically requested.
- If you are in therapy or being tested by order of court of law the results of the treatment or tests must be revealed to the court.
- If there is evidence to suspect child abuse either by neglect, assault, battery, or sexual molestation, I must report it to the appropriate agency.
- If you disclose viewing of child pornography, I must report to the appropriate agency (Code AB1775)
- If there is evidence to suspect elder and/or dependent adult abuse I must report the reasonable suspicion to the appropriate agency.
- In the case of potential suicide, I am allowed by law to inform the necessary individuals and/or agencies to prevent harm

I am mandated by law to reveal the above information obtained during therapy to other persons or agencies without your permission and I am not required by law to inform you of my actions in this regard. Additional Privacy Rights are discussed in the NOTICE OF PATIENT INFORMATION PRACTICES document.

If at any time you have questions regarding this form or any other aspect of counseling which I have not answered to your satisfaction please feel free to contact me by phone or discuss with me in session.

I have read and understand this document and all my questions regarding the above have been answered to my satisfaction and acknowledge that I have received a copy of the NOTICE OF PATIENT INFORMATION PRACTICES of New Day Women's Center.

Print Client Name(s) _____

Client Signature(s) _____

Date _____ Phone # _____

Mailing Address _____

Therapy Financial Agreement

I have discussed the financial arrangement with my therapist/counselor and hereby agree to the following:

Per session rate: \$ 125 *Regular fee unless discount/sliding scale is approved

Contract rate per session: \$ _____

Amount paid by client: \$ _____ *Due at each session

Amount paid by Third Party: \$ _____ *Includes **approved** sponsorships, scholarships, insurance or discounts

Third Party Information (name, address, phone number): _____

I give consent to New Day Women's Center to contact the Third Party named above to exchange information relevant to billing purposes only. ***Understand that if the Third Party does not pay, for whatever reason, I am responsible for the entire contract rate per session.*** *Note that NDWC scholarships and most insurance and 3rd party payers **DO NOT** cover short cancellation fees and "no show" fees. In these cases, the FULL session contract rate of \$ _____ must be paid by the client prior to scheduling the next session.

Appointments: All appointments will be made through my therapist/counselor _____. If an appointment cancellation or rescheduling becomes necessary, at least 24 hours advance notice is required to avoid being charged. As a courtesy, this enables other clients to utilize this time.

Cancellations not made within 24 hours of the scheduled appointment are subject to a charge of 100% of the session fee. In the case of a no-show or cancellation, the client will be required to reschedule the next appointment; No appointment will be carried over without direct contact. Please be advised that I may refuse to reschedule an appointment for a client who has canceled or not shown repeatedly, or for a client who has a large outstanding balance and has not made and maintained a financial arrangement.

Payments: Cash, checks, credit and debit cards are accepted as payment. **Returned checks will be subject to a \$15.00 service fee.**

Rates: Rates are subject to change due to increased cost of living. In this case, advance notification of a minimum of 30 days will be given along with the opportunity to discuss options to enable you to continue therapy without undue financial burden. As your therapist, I will do everything possible to work with you.

If therapy services have terminated, or if there is a 90+ day gap between therapy sessions, rates will be updated upon return according to the most recent fee guidelines.

I have read and understand the "Financial Agreement" document.

(Client Signature)

(Date)

(Client Signature)

(Date)

(Signature of Responsible Party if client is minor)

(Date)

Rating Scale of Individual Problem

INSTRUCTIONS: Rate each item by putting a number 1 to 3 next to those items listed which you've experienced or are currently experiencing.

SCALE: 1 = Mildly 2 = Moderately 3 = Severely

Emotional Concerns

- | | |
|---|--|
| <input type="checkbox"/> Feeling anxious or uptight | <input type="checkbox"/> Feeling depressed or sad |
| <input type="checkbox"/> Excessive worrying | <input type="checkbox"/> Being tired or lacking energy |
| <input type="checkbox"/> Not being able to relax | <input type="checkbox"/> Feeling unmotivated |
| <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Loss of interest in many things |
| <input type="checkbox"/> Unable to calm yourself down | <input type="checkbox"/> Having trouble concentrating |
| <input type="checkbox"/> Dwelling on certain thoughts or images | <input type="checkbox"/> Having trouble making decisions |
| <input type="checkbox"/> Fearing something terrible about to happen | <input type="checkbox"/> Feeling future is hopeless |
| <input type="checkbox"/> Avoiding certain thoughts or feelings | <input type="checkbox"/> Feeling worthless or a failure |
| <input type="checkbox"/> Having strong fears | <input type="checkbox"/> Being unhappy all the time |
| <input type="checkbox"/> Worrying about nervous breakdown | <input type="checkbox"/> Dissatisfied with physical appearance |
| <input type="checkbox"/> Feeling out of control | <input type="checkbox"/> Feeling self critical or blaming yourself |
| <input type="checkbox"/> Avoiding being with people | <input type="checkbox"/> Having negative thoughts |
| <input type="checkbox"/> Fears of being alone or abandoned | <input type="checkbox"/> Crying often |
| <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Feeling empty |
| <input type="checkbox"/> Having nightmares | <input type="checkbox"/> Withdrawing inside yourself |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Thinking too much about death |
| <input type="checkbox"/> Troubling or painful memories | <input type="checkbox"/> Thoughts about hurting yourself |
| <input type="checkbox"/> Missing periods of time - can't remember | <input type="checkbox"/> Thoughts of killing yourself |
| <input type="checkbox"/> Trouble remembering things | <input type="checkbox"/> Frequent mood swings |
| <input type="checkbox"/> Feeling numb instead of upset | <input type="checkbox"/> Feeling resentful or angry |
| <input type="checkbox"/> Feeling detached from all or part of your body | <input type="checkbox"/> Feeling irritable or frustrated |
| <input type="checkbox"/> Feeling unreal, strange, or foggy | <input type="checkbox"/> Feeling rage |
| <input type="checkbox"/> Feeling like hurting someone | |

Behavioral and Physical Concerns

- | | |
|--|---|
| <input type="checkbox"/> Not having an appetite | <input type="checkbox"/> Aggressive towards others |
| <input type="checkbox"/> Binge eating | <input type="checkbox"/> Impulsive reactions |
| <input type="checkbox"/> Self inducing vomiting for weight control | <input type="checkbox"/> Trouble finishing things |
| <input type="checkbox"/> Using laxatives for weight control | <input type="checkbox"/> Working too hard |
| <input type="checkbox"/> Eating too much | <input type="checkbox"/> Using alcohol too much |
| <input type="checkbox"/> Eating too little | <input type="checkbox"/> Being alcoholic |
| <input type="checkbox"/> Losing weight - how much? _____ | <input type="checkbox"/> Using drugs |
| <input type="checkbox"/> Gaining weight - how much? _____ | <input type="checkbox"/> Driving under the influence |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Blackouts after drinking |
| <input type="checkbox"/> Early morning awakening | <input type="checkbox"/> Sleeping too much |
| <input type="checkbox"/> Sleeping too little | <input type="checkbox"/> Lack of exercise |
| <input type="checkbox"/> Not having leisure activities | <input type="checkbox"/> Too much exercise |
| <input type="checkbox"/> Smoking cigarettes | <input type="checkbox"/> Often spending in binges |
| <input type="checkbox"/> Temper outburst | <input type="checkbox"/> # of hours I usually sleep _____ |

YES or NO Have you ever felt you ought to cut down on drinking or drug use? **CIRCLE ONE**

YES or NO Have people annoyed you by criticizing your drinking or drug use? **CIRCLE ONE**

YES or NO Have you ever felt bad or guilty about your drinking or drug use? **CIRCLE ONE**

YES or NO Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover? **CIRCLE ONE**

Intimate Relationship Concerns

- Feeling misunderstood in relationship
- Not feeling close enough to partner
- Trouble communicating with partner
- Not trusting partner
- Lack of respect by partner
- Partner being secretive
- Lack of shared interests
- Lack of time with other couples
- Jealousy in relationship
- Frequent arguments
- Trouble resolving conflict
- Partner being demanding or controlling
- Violent arguments
- Emotional abuse in relationship
- Physical abuse in relationship
- Sexual abuse in relationship

- Lack of fairness in relationship
- Problems with dividing household tasks
- Disagreeing about children
- Lack of affection
- Unsatisfactory sexual relationship
- Lack of time together
- Lack of positive interaction
- Partner having alcohol or drug problems
- Self or partner having an affair
- Feeling uncommitted to relationship
- Wanting to separate
- Discussing separating or divorce
- Problems with in-laws
- Problems with ex-partner
- Problems with step parents
- Children having special problems

Sexual Concerns

- Worrying about getting pregnant
- Having miscarriage(s)
- Choice of birth control
- Having an abortion
- Not able to become pregnant
- Not enjoying sexual affection
- Too tired to have sex

- Too anxious to have sex
- Feeling a lack of sexual desire
- Wanting to have sex more often
- Feeling neglected sexually
- Feeling used sexually
- Being unable to sustain an erection
- Feeling negatively about sex

When Growing Up to Present Time

- Being physically abused - by whom?
- Being emotionally abused - by whom?
- Being sexually abused - by whom?
- Having an alcoholic parent - which?
- Having a drug abusing parent - which?
- Having a depressed parent - which?
- Having a parent with emotional problems
- Having parents separate or divorce

- Close family member dying - who?
- Felt neglected or unloved - by whom?
- Having an unhappy childhood
- Having serious medical problems - what?
- Having drug or alcoholic problems
- Frequent moves
- Having learning problems - what?
- Having attempted suicide - when?

Stresses During the Past Several Years

- Death of a family member or friend - who?
- Birth or adoption of a child
- Self or family member hospitalized - who?
- Moved
- Being harassed or assaulted
- Frequent family or couple arguments
- Separation/divorce

- An important relationship ending - who?
- Losing or changing job
- Financial trouble
- Legal problems
- Natural disaster
- Serious or chronic illness - what? _____
- _____
- Other

Please State Your Goals for Therapy:

1. _____

2. _____

3. _____

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and about how you can get access to that information. Please review this carefully.

New Day Women's Center's Legal Duty

New Day Women's Center is required by law to protect the privacy of client's personal health information, provide this notice about our information practices to all clients and to follow the information practices that are described herein.

Uses and Disclosures of Health Information

New Day Women's Center uses your personal health information for the following: treatment, for obtaining payment for treatment, conducting internal administrative activities and for evaluating the quality of care that we provide. For example, it is possible that we may use your personal health information to contact you to provide appointment reminders, about information on treatment alternatives or other health related benefits that could be of interest to you.

New Day Women's Center may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release information for any reason, every client has the right to later revoke that authorization to stop future disclosure at any time.

New Day Women's Center may change policy at any time. When changes are made, a new form will be posted in the waiting room and patient exam areas as well as given to every client upon their next visit. You may also request an updated copy of this document at any time.

Patient's Individual Rights

Every client has the right to review or obtain a copy of your own personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes, except when specifically authorized by you or when required by law or in emergency circumstances. New Day Women's Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our privacy officer at the number below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact our office at (619) 713-1544.

Acknowledgement of Licensure Status and Clinical Supervision

By signing this I, _____, attest to being informed that I am receiving counseling from _____ (name of therapist) who is ___ a BBS Licensed MFT, ___ a BBS registered Associate MFT or Associate LPCC, or ___ a Practicum Student Trainee. I understand that my therapist is under the direct supervision of New Day Women's Center's clinical director, Phyllis Vokey Long, LMFT who is licensed by the California Board of Behavioral Sciences (MFC#43695) and that my confidentiality with my therapist also extends to the supervisor and supervision group (counselors and therapists of New Day Women's Center).

I understand that New Day Women's Center is a non-profit charitable organization and as a result, the civil liabilities of both the charitable organization and an employee of the charitable organization are limited to money damages of \$500,000 for each person, \$1,000,000 for each occurrence of bodily injury or death, and \$100,000 for each occurrence of injury to property. These limits apply to the employee and the organization separately; they are not aggregate limits.

I have read the above information and have had my questions answered to my satisfaction. I have also been given the name and phone number of the supervisor responsible for my therapist, should I feel the need to contact her for any reason.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

A NOTICE TO CLIENTS: The office of New Day Women's Center receives and responds to complaints regarding the practice of psychotherapy by any *unlicensed or unregistered counselor* by either emailing phyllis@newdaywomenscenter.com or by calling (619) 713-1544.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of *licensed marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors*. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.