New Day Women's Center
5575 Lake Park Way, Suite 106
La Mesa, CA 91942
(619) 713-1544

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/Pacidic 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. ***I 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

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

Behavioral and Physical Concerns

___ Not having an appetite
___ Binge eating
___ Self inducing vomiting for weight control
___ Using laxatives for weight control
___ Eating too much
___ Eating too little
___ Losing weight - how much? ____
___ Gaining weight - how much? ____
___ Trouble sleeping
___ Early morning awakening
___ Sleeping too little
___ Not having leisure activities
___ Smoking cigarettes
___ Temper outburst
___ Aggressive towards others
___ Impulsive reactions
___ Trouble finishing things
___ Working too hard
___ Using alcohol too much
___ Being alcoholic
___ Using drugs
___ Driving under the influence
___ Blackouts after drinking
___ Sleeping too much
___ Lack of exercise
___ Too much exercise
___ Often spending in binges
# 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.

Consent To Treat A Minor

Client: _____ Date: _____

I hereby give my permission for my son, daughter, or minor, for whom I am legal guardian, who is named above, to receive psychotherapy from _____ at New Day Women's Center.

Signature: _____

Relationship: _____