

**Adult New Patient Intake Form (online fillable)**

**This is the intake paper work for Empowering Choices Counseling & Consultation. We understand that this is a long packet and that some of our questions are in-depth, and we understand they may, at times, ask for personal information, but it is intended to be an all-inclusive look at you as a person. Our intent is to collect as much information as we can about you in-order-to provide the best counseling services we can for you. If there are questions that you do not feel comfortable answering or would rather talk with your counselor about, please mark “Will talk to my counselor about”. Please return the paper work to your counselor on your initial session.**

**Name:**

|  |  |  |
| --- | --- | --- |
| Today’s Date:  |  | Date of Birth:  |
| Age:  | Gender:  | Street Address:  |
| City:  | State:  | Zip Code:  |
| Phone (Home):  |  | (Cell):  |
| May we leave messages for you?  | Home: Yes [ ]  No [ ]  | On Cell: Yes [ ]  No [ ]  |
| Preferred Contact E-Mail Address:  |  |  |
| Emergency Contact Name:  |  | Relationship:  |
| Emergency Contact Phone Number:  |  |  |
| How did you hear about us?  |  |  |

|  |
| --- |
| Correspondence:  |
| Can we mail correspondence to this address? Please Initial: [ ]  Yes [ ]  No  |
| Home Ph: Is it alright to contact and leave message? Please Initial: [ ]  Yes [ ]  No  |
| Work Ph: Is it alright to contact and leave message? Please Initial [ ]  Yes [ ]  No  |
| Cell Ph: Is it alright to contact and leave message? Please Initial [ ]  Yes [ ]  No  |
| E-Mail: Is it alright to contact by e-mail? Please Initial [ ] Yes [ ]  No  |

*Family Relationships*

**Do you have any children?:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Age** | **Sex** | **Custody?****Y/N** | **Lives With?** | **Amount of Custody** |
| 1.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 2.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 3.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 4.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 5.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 6.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 7.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 8.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |
| 9.  |   | [ ]  M [ ]  F | [ ]  yes [ ]  no | [ ]  yes [ ]  no |   |

**Who else lives with the client?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Sex** | **Relationship** | **Additional Information** |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| **Primary language of the household/family:**  | **Secondary:**  |

|  |
| --- |
| Family Information |
| Relationship status: [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Single  |
| How would you describe your relationship with your children?  |
| Long term relationship: Yes [ ]  No [ ]  How long?  |
| If in a committed relationship, how would you describe your relationship?  |
| Partner’s Name:  |
| How would you describe your relationship with your partner’s children?:  |
| Current Employment Status: Full Time: [ ]  Part Time [ ]  Not Employed [ ]  Retired [ ]  Student [ ]  Where:  |
| Religion:  |
| Cultural Affiliation:  |
| Have you had counseling in the past?: [ ]  **Yes** [ ]  **No If so, who:**  |

*History of mental health problems/diagnosis/treatment?*

|  |  |  |
| --- | --- | --- |
| *Diagnosis* | *Date/Age* | *Who did the diagnosis?*  |
| 1.
 |   |   |
| 1.
 |   |   |
| 1.
 |   |   |
| 1.
 |   |   |

|  |
| --- |
| Does anyone in your direct or extended family have mental illness:  |

*Empowering Choices Rates for Services, Policies & Procedures*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Service** | **Initial Visit Cost** | **Cost per Session** | **Number of Sessions** | **Other Services Cost** |
| **Community Counseling and Other Services** |  |  |  |  |
| Mental Health Assessment | $500 for Assessment |  | 1-3 sessions; may require additional records |  |
| Individual therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| ABA Therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| Family Therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| Subpoenaed | $150 per hourSee Section below on court related issues and costs |  |  |  |
| Filling a document with the court | $100 |  |  |  |
| Group Therapy |  | $50 per hour | Groups normally run for a certain number of sessions |  |
| Life Coaching |  | $150 per hour | Varies |  |
| Work shops |  | Varied |  |  |
| Seminars |  | Varied |  | Regular Rate: $150 per hour for a group of 6 and under; $25 per person for a group of 7 or more.Nonprofit Rate: $100 per hour for a group of 6 and under; $15 per person for a group of 7 or more. |
| Consultation | $150 per hour/or sliding scale | $150 per hour/or sliding scale |  |  |
| NSF Check fee – Returned Checks | $30 per check |  |  |  |
| Phone calls |  |  |  | $25 per quarter hour |
| Letters/Reports (including pet letters) |  |  |  | $50 per page |
| Case Management | $150 per hour/or sliding scale |  |  |  |
| Consultation | $150 per hour/or sliding scale |  |  |  |
| Functional Assessment | $400-800 |  | Cost depends on time required to perform the assessment |  |
| School Consultation | Regular determined session fee | Regular determined session fee |  |  |
| Behavioral Planning | $85 PER HOUR |  | Varies |  |
| Behavioral Consultant | $85  |  | Varies |  |
| Copies of paperwork where applicable |  |  |  | .15 per page |

*The following statement expresses the current policies and procedures of this office. Please read it carefully and if you have any questions, ask your counselor for additional information and/or clarifications.*

# **Your health record contains personal information about you.  This information may identify you as it relates to your past, present or future physical and/or mental health condition(s) and related healthcare services.  This information is commonly referred to as Protected Health Information (PHI). Please understand, that any information we obtain or receive is only to assist our client in their growth and healing through the counseling process. This Notice of Privacy Practices describes how Empowering Choices Counseling and Consultation (ECCC) may use and disclose your PHI in accordance with state and federal law which includes the Health Insurance Portability and Accountability Act (HIPAA) regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.**

# **Our Obligations:**

# **ECCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. ECCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practice will be effective for all PHI that we maintain at that time. ECCC will provide you with a copy of the revised Notice of Privacy by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**

**Uses and Disclosure. ECCC may use and disclose protected health information without your consent in the following ways:**

 **Child Abuse or Neglect**

**Judicial and Administrative Proceedings**

 **Deceased Patients (with your prior signed consent)**

 **Abuse of and elderly or vulnerable adult**

 **Medical Emergencies**

 **To those you give consent too. Such as: friends and family also involved in your treatment.**

 **Law Enforcement (but only absolutely necessary information to the emergency)**

 **Health Oversight Agencies**

 **Public Health (preventing, treating, or controlling diseases)**

 **Public Safety**

 **Verbal Permission (once you have given it and to be followed by a signed release)**

 **Other members of our clinic team for consultation**

# **Professional Ethics and Accountability:** Empowering Choices Counseling and Consultation is a community of clinicians with a mission to provide compassionate and competent counseling services to children, adolescents, individuals, couples, and families. We are a group of professionals, most of which are preliscensed professionals, who practice according to the state board Code of Ethics. We encourage you to ask any further questions concerning our academic preparation, counselor training, professional credentials, theoretical orientations, case consultation, clinical supervision, or continuing education.

**Treatment Risks and Alternatives:** Please be informed that there are risks involved in the counseling process. For example, some people experience an increase in stress, especially during the early stages of treatment. In some cases, a discussion of long-standing unresolved issues can seem to aggravate rather than alleviate a problem. These are natural occurrences of which you need to be aware. While we cannot guarantee the success of our outcomes, we nonetheless intend and attempt to provide you with the highest possible quality of care. If we determine we cannot provide treatment to meet your personal or particular needs, your counselor will inform you at the earliest opportunity and assist you in finding more appropriate services.

In addition to providing direct services, Empowering Choices Counseling and Consultation offers clinical training, experience, and supervision to post-graduate residents pursuing their professional credentials. Occasionally, these counselors will require recordings of their clinical work with clients to serve their educational needs. Accordingly, your counselor may ask your permission to record a session. Please allow your personal discretion to inform your consent. If you feel hesitant to give permission, speak with your counselor about your reluctance, or simply say “I would rather not.” Recordings are subject to our strict policy of confidentiality, are used exclusively to assist supervisors in helping counselors to develop their clinical skills and are destroyed immediately following their use in supervision.

**Legal Issues and Proceedings:** Our mission includes helping children, adolescents, individuals, couples, and families resolve their psychological, spiritual and relationship conflicts through the counseling process; rather, than providing them advocacy, evaluation or testimony in the judicial system (see legal preceding below). If you need a forensic assessment or a clinician who will testify in court, we will attempt to assist you in finding a provider who offers those services.

**Legal Proceedings: As clinicians, we understand that we may be called into court to testify at times. When we are called to testify, we are bound by ethics to answer things honestly. This does not mean that your clinician’s testimony will be solely in your favor. In many ways our hands are “tied” to answering the specific questions of the prosecution and defense. We are not allowed to freely advocate for our clients as we would and could do in other situations such as: with doctor, schools, other professionals, etc. We can only testify to the facts of a case and not to our professional opinion. Due to these specific limitations, as a general rule, we discourage you from having your therapist subpoenaed into court. If and when we are subpoenaed, we do charge for the time we have to move other clients or block out times within our schedule too travel too and appear in court (See our rate of pay chart above). In addiction to our general rate, clients may be responsible for all attorney fees and costs incurred by the therapist as a result of the legal action.**

**Office Hours:** Office hours are by appointment only. Appointments are forty-five (50) minute sessions and begin promptly at the appointed time. Each clinician primary keeps control of their own appointments and availability.

**Initial Sessions:** Your first appointment will be a fifty (50) minute session with one of our counselors. The counselor will review the information you shared when you called for your appointment, listen to your concerns and assess your needs, answer any of your questions, and plan with you how to proceed. You may decide mutually to work together, be referred to another clinician at Empowering Choices Counseling and Consultation or be referred to another person or agency in the community for appropriate assistance.

**Fees**: The standard fee for service at Empowering Choices Counseling and Consultation is $150.00 per session. If you need an adjusted fee based on your ability to pay, please ask your counselor for a copy of the Fee Adjustment Scale which is our sliding scale.

**Payment Policy:** Our policy is to receive payment in full at each session unless you make arrangements with your individual counselor. Please make checks payable to “ECCC” (i.e., Empowering Choices Counseling and Consultation).

**Insurance. ECCC is currently credentialed as an: In-Network-Provider with several insurance companies such as: Regence Blue Cross/ Blue Shield, Moda, Providence, and Oregon Health Plan (OHP). As we are working to continually be credentialed into other insurance companies, this list may continually grow. Check our website under “Insurances”.** Although our clinic may not be set up directly with other insurance companies, a large number of insurance companies will work with us as what is referred to as: **Out of Network Providers** on several different levels. On our website, under “payments” we explain how to talk to your insurance company to see if they will allow us to bill them for our services. Some insurance plans do reimbursements or allow you to use health savings plans. Please check with your insurance company prior to your appointment. We will be happy to do what we can in talking with your insurance company; however, you are responsible for keeping current with payments.

**Cancellation Policy:** Our policy is to charge a “$40” fee for all cancelations and missed sessions that are under 24 hours except in the case of occasional emergences. We feel that in under 24 hours, the “$40” will cover the clinicians struggle to fill their time slot. Our company feels that a cancelation over 24 hours gives the clinician a fair amount of time to fill the time slot on their own which helps us keep the lights on.

**Telephone Calls:** See table at the beginning of this paperwork or on the website under “payments”**.**

**Emergency Procedures:** Empowering Choices Counseling and Consultation is not a crisis response facility. **In the event of an emergency—defined here as an imminent danger to yourself, others or both—please call 9-1-1 for immediate assistance.**

**Support Services:** All functions concerning billing and payment, insurance reimbursement, case documentation, and other support services are provided with the same concern for professionalism and quality. In order to protect your confidentiality, a written authorization will be required for the release of information. A service fee may be charged for duplication, summarization, and other document preparation. Many of our prices are listed on the table at the beginning of this paperwork or on our website under **“Payments”**. Please direct any questions about any other services you do not see listed to your counselor. At this time, ECCC does not provide general case management, medication management, and or housing; however, our counselors do have access to other community resources and/or agencies which do provide those services.

**Consent to Treatment:** I have read the above information about which I have had the opportunity to ask questions. I understand the limits of confidentiality and the risks associated with counseling. If there are children involved in counseling, I hereby consent to their treatment and affirm I am the legal guardian with the authority to consent to their treatment. I agree to the payment and billing policies outlined above and accept full responsibility for any and all fees charged for counseling sessions, cancellations, or missed appointments. I consent to participate in counseling and understand that I may decline services at any time. I am aware that my counselor may consult periodically on client issues with other clinicians at Empowering Choices Counseling and Consultation, with clinical supervisors, or both. My signature below indicates that I have read, understand, and agree to accept the policies outlined on both sides of this document, and have received a copy of these policies for further reference.

[ ]  I agree to pay the standard fee of $150. **OR** [ ]  I need an adjusted fee based on my ability to pay.

[ ]  I have received a copy of Empowering Choices Counseling & Consultation for Protecting Client Privacy (HIPAA).

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Counselor Signature: |  | Date: |  |

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*Empowering Choices Counseling & Consultation Authorization for Insurance Billing*

Counselor: Client:

Please check with your insurance company (there are tips on our web site) prior to receiving services to answer the following questions:

 [ ]  Deductible Amount-How much of your deductible have you met for the current year?: [ ]  Co-Pay Amount:

[ ]  Does your insurance require pre-authorization?:

[ ]  Anniversary date of Coverage:

[ ]  Copy of insurance card has been provided:

***A copy of the insurance card will be required at the time of initial visit***

 **(Fill out the following ONLY if copy of card was NOT provided)**

**Primary Insurance**: ID#: Group#:

Subscriber (Name on policy): DOB:

Employer:

**Secondary Insurance**: ID#: Group#:

Subscriber (Name on policy): DOB:

Employer:

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Empowering Choices Counseling & Consultation directly for services rendered according to my mental health coverage. I authorize Empowering Choices Counseling & Consultation to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor’s referral if required. I understand that I am financially responsible for services performed, whether or not, paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. I understand I am responsible for a $40 cancelation fee per session canceled without a 24 hour notice.

Signature of client or responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Questions for Therapy*

**In order for us to provide the most complete care to you as our clients, please complete this form. If you are not sure about any of the questions, or feel uncomfortable answering them, please feel you can leave them blank. Feel free to speak with your counselor about any areas of concern you have.**

Please describe the problem that has led you to seek our services at this time.

Are there things you would like to specifically address in therapy?

How would you describe your current treatment for any mental health symptoms you are experiencing? (None [ ] )

How long ago did the problem begin?

What are your strengths?:

What are you current hobbies?:

Past hobbies?:

Current Interests?:

Past Interests?:

*Areas of concern. Please check all as they apply.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Emotional Struggles** | **Current problem** | **Problem in past** | **No problem** |
| Anxiety (worry, fear, excessive guilt) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Depression (unhappiness, lack of energy) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Thinking Problems (disorganized, confused, unable to focus) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Uncontrolled repetition in thinking and/or behavior. | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Mood Swings (change quickly, hard to control, feeling “numb”) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Anger | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Grief (feelings of loss, sadness, crying) | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Suicidal Thinking or Action | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Nightmares/Sleep Disturbances | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Withdrawn/Few Friends | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Panic Attacks | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Nervous or Repetitive Habits | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Trauma and/or Abuse | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Emptiness | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Loneliness | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Flashbacks | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Difficulty Concentrating | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Irritability | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Delusions, False Beliefs | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Hallucinations | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Seasonal Mood Changes | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Obsessive Thoughts | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Impulsivity | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Recurring Thoughts | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Feeling Worthless | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| **Behavioral Struggles** |  |  |  |
| Employment  | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Legal Problems | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Physical Abuse | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Marital Conflict | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Sexual Abuse | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Academic Difficulties | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Sextual Assault | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Anorexia | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Bulimia | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Withdrawn, Isolated | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Aggressive Behavior | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Problems with Pornography | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Computer Addiction | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Social Media Addiction | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Self-injury or Cutting  | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Violent Behaviors | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Gambling | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Stealing | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Sexual Problems | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Obsessions/Compulsions | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Problems with Attention | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Eating Problems | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Learning Problems | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Financial Problems | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]
| Setting Fires | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |[ ]

*Medical Background*

|  |
| --- |
| Has you experienced any of the following medical conditions during his/her lifetime?[ ]  Allergies [ ]  Surgery [ ]  Serious Accident [ ]  Head Injury[ ]  Chronic Pain [ ]  Asthma [ ]  Headaches [ ]  Stomach problems[ ]  Dizziness/fainting [ ]  Meingitis [ ]  Seizures [ ]  Vision Problems[ ]  High Fevers [ ]  Diabetes [ ]  Hearing Problems [ ]  Miscarriage[ ]  Epilepsy or seizures [ ]  Abortion [ ]  Sleep Disorder[ ]  Thyroid Disease [ ]  Cancer [ ]  Heart Disease [ ]  Kidney Disease[ ]  Fibromyalgia [ ]  Other: Please list any CURRENT health concerns:  |

|  |
| --- |
| Current prescriptions medications: [ ]  None |
| Medication | Dosage | Date First Prescribed | Prescribed By |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
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| --- |
| Name of primary care physician:  |

|  |
| --- |
| Previous Mental Health Treatment |
| Yes | No | Type of treatment | When? | Provider/Program | Reason for Treatment |
|   |   | Outpatient Counseling |   |   |   |
|   |   | Medication (Mental Health) |   |   |   |
|   |   | Psychiatric Hospitalization |   |   |   |
|   |   | Drug/Alcohol Treatment |   |   |   |
|   |   | Self-help/Support Groups |   |   |   |

|  |
| --- |
| Mental Health  |
| Current Symptoms Checklist: (check which ones apply) |
|  [ ]  Depressed mood [ ]  Racing thoughts [ ]  Excessive worry [ ]  Unable to enjoy activities [ ]  Impulsivity [ ]  Anxiety attacks [ ]  Sleep pattern disturbance [ ]  Increased risky behavior [ ]  Avoidance [ ]  Loss of interest [ ]  Increased libido [ ]  Hallucinations [ ]  Concentration/forgetfulness [ ]  Decreased need for sleep [ ]  Suspiciousness [ ]  Change in appetite [ ]  Excessive energy [ ]  Fatigue [ ]  Excessive guilt [ ]  Increased irritability [ ]   [ ]  Decreased libido [ ]  Crying spells [ ]   |
| Suicide Risk Assessment |
| Have you ever had feelings or thoughts that you didn’t want to live?: [ ]  Yes [ ]  NoIf “Yes”, pleas answer the following. If “No”, please skip to the next section.Do you currently feel that you don’t want to live?: [ ]  Yes [ ]  NoHow often do you have these thoughts?: When was the last time you had thoughts of dying?: Has anything happened recently to make you feel this way?: On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?: Would anything make it better?: Have you ever thought about how you would kill yourself:: Is there anything that would stop you from killing yourself?: Do you feel hopeless and/or worthless?: Have you ever tried to kill or harm yourself before?:  |
| Substance Use: |
| Have you ever been treated for alcohol or drug use or abuse [ ]  Yes [ ]  NoHow many days per week do you drink any alcohol? What is the most number of drinks you will drink in a day? What is the least number of drinks you will drink in a day? In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? Have you ever felt you ought to cut down on your drinking or drug use? [ ]  Yes [ ]  NoHave people annoyed you by criticizing your drinking or drug use? [ ]  Yes [ ]  NoHave you ever felt bad or guilty about your drinking or drug use? [ ]  Yes [ ]  NoHave you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? [ ]  Yes [ ]  NoDo you think you may have a problem with alcohol or drug use? [ ]  Yes [ ]  NoHave you used any street drugs in the past 3 months? [ ]  Yes [ ]  NoIf yes, which ones? Have you ever abused prescription medication? [ ]  Yes [ ]  NoIf yes, which ones and for how long?  |
| Check if you have ever tried the following: |
|  [ ]  Methamphetamine [ ]  Cocaine [ ]  Stimulants (pills) [ ]  Heroin [ ]  Marijuana [ ]  LSD or Hallucinogens [ ]  Pain killers (not as prescribed) [ ]  Methadone [ ]  Tranquilizers/sleeping pills [ ]  Alcohol [ ]  Ecstasy [ ]  Other |
| How long did you use the substances you checked?  |

Personal Disclosure Statement

Amber Sirstad

Empowering Choices

147 Commercial St. NW Suit 15

Salem, OR 97301

Email: asirstad@hotmail.com

**Philosophy and Approach:**

My main theoretical approach for therapy is person-centered, as well as drawing from a cognitive-behavioral approach. I believe people have self-awareness, personal strength, truthfulness and can be personally resourceful in these capabilities to create change in their lives. I work toward the goal of creating an atmosphere of comfort for the client based on trust, understanding, and unconditional positive regard while remaining attentive.

**Formal Education and Training:**

I received my B.S. in Psychology through Liberty University in May, 2016. I received my Masters of Arts degree in Counseling through Corban University in December, 2016. I did my Masters level internship at the Washington County Jail in Hillsboro, OR.

**As a client of an Oregon Registered Intern, you have the following rights:**

1. To expect that an intern has met the minimal qualifications of training and experience required by state law;

2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;

3. To obtain a copy of the Code of Ethics;

4. To report complaints to the Board;

5. To be informed of the cost of professional services before receiving the services;

6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: A) Reporting suspected child abuse; B) Reporting imminent danger to client or others; C) Reporting information required in court proceedings or by the client’s insurance company, or other relevant agencies; D) Providing information concerning licensee case consultation or supervision; E) Defending claims brought by client against licensee; and F) To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

**Fee Schedule:** The standard fee for counseling services is $100 per 50 minute session; however, I do have a sliding fee scale which is available upon request.

If you have any concerns or questions about your meeting with me, you may contact my clinical supervisor, Bob Powell at 971-645-8397, or the Oregon Board of Licensed Professional Counselors and Therapists:

Board of Counselors and Therapists

3218 Pringle Rd SE #250, Salem, OR 97302-6312

(503) 378-5499

Email: lpct.board@state.or.us Website: [www.oregon.gov/OBLPCT](http://www.oregon.gov/OBLPCT)

Please sign and date. A copy will be given to you for your records.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intern Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_