

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

**Below is the intake paperwork 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 paperwork to your counselor on your initial session.**

***\*The primary adult client needs to fill out the first section of this paperwork***

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

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| --- |
| Correspondence: |
| Can we mail correspondence to this address? Please Initial: ☐ Yes ☐ No |
| May we call and leave a message on your cell phone? Please Initial: ☐ Yes ☐ No |
| May we call and leave a message on your other phone? Please Initial: ☐ Yes ☐ No |
| May we contact you by e-mail? Please Initial: ☐ Yes ☐ No |

*Empowering Choices Rates for Services, Policies & Procedures*

|  |  |
| --- | --- |
| **Type of Service** | **Cost** |
| Mental Health Therapy and Assessments;  Personal, School, or Behavioral Consultation;  Case Management | $250 for a 50 minute session with a Licensed Professional Counselor.  $200 for a 50 minute session with a Professional Counselor Associate.  $150 for a 50 minute session with a Masters-level student-intern. |
| Subpoenaing your counselor | Same hourly fee as counselor’s therapy rate |
| Group Therapy | $75 per hour |
| Seminars | Regular Rate: $200 per hour for a group of 6 and under; $30 per person per hour for a group of 7 or more.  Non-profit discount rate available |
| Not Sufficient Funds Check fee – Returned Checks | $30 per check plus any bank charges we are billed.  Must be paid with cash or card |
| Functional Assessment | $400-800 |
| Copies of paperwork where applicable | .15 per page |

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**Informed Consent Information**

*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 pre-licensed 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 doctors, 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 to travel too and appear in court (See our rate of pay chart above). In addition 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 fifty minute sessions and begin promptly at the appointed time. Each clinician primarily keeps control of their own appointments and availability.

**Initial Sessions:**

Your first appointment will be a fifty 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- $250.00 per session, depending on the clinician. 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 Empowering Choices Counseling and Consultation, pay in cash with exact change, or pay online through our website.

**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 cancellations and missed sessions that are under 24 hours except in the case of occasional emergencies. We feel that in under 24 hours, the $40 will cover the clinicians’ struggle to fill their time slot. Our company feels that a cancellation 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.

**End of Services:**

Your status as a client with Empowering Choices will automatically end 30 days after our last contact. Additionally, you or your counselor may end the relationship earlier as needed. If you owe Empowering Choices more than $300, we reserve the right to stop counseling sessions until the balance is paid.

**Communicating with your Counselor:**

Electronic communication such as emails and texts have risks in their use. They can potentially be intercepted and read by others who you do not want seeing them. Empowering Choices cannot guarantee but will use reasonable means to maintain the security and confidentiality of email, phone, voicemail, and text information sent and received. ECCC is not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct.

Your counselor may communicate with you about some subjects such as scheduling through email or text. However, complex information should not be communicated through email or text. Please call and/or schedule an appointment to discuss complex and/or sensitive information. Electronic information and messages received and sent may be printed and filed in your record.

**Social Media:**

Your counselor will not communicate with you via social media systems such as Facebook and Twitter and you are not expected to "like" or "follow" any social media accounts of Empowering Choices or our staff. You are not expected to leave us positive reviews anywhere online. If you have concerns about our services, please reach out to us. We would be happy to address your concerns to the best of our abilities. We believe connecting with clients on social media would compromise your confidentiality and potentially negatively impact the counseling relationship.

**Internet Searches:**

It is our policy to not search out information about you on the internet using systems like Google. In the case of an emergency, we may attempt to find out information using the internet if it relates to your health and safety.

**Letter Writing:**

If you request a written letter from your counselor for accommodations or other needs, your counselor will take your request into consideration. We will discuss your request with you and determine if it is within our scope of practice, ethics, and training to be able to write the letter you request. We will not be able to accommodate all letter writing requests and writing a letter may incur an additional expense per our fee schedule above. Insurance companies may not cover the writing of accommodation letters.

**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-$250 as agreed upon by Empowering Choices.

☐I will be using my insurance and agree to pay the contracted co-pay**.**

☐ I need an adjusted fee based on my ability to pay. Agreed fee amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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**Authorization for Insurance Billing**

**Counselor:**  **Client:**

Please check with your insurance company (there are tips on our website) 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 cancellation fee per session canceled without a 24-hour notice.

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

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**Family Intake Questionnaire**

**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.**

*Family Information*

**Mothers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Fathers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: ☐ Same as above** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parents’ Relationship Status: ☐ Married ☐ Separated/Divorced ☐ Never Married**

**☐ Single ☐ Engaged**

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| --- | --- | --- | --- | --- |
| **Child’s Name** | **DOB** | **Age** | **Grade** | **Sex** |
| **1.** |  |  |  | ☐ M ☐ F |
| **2.** |  |  |  | ☐ M ☐ F |
| **3.** |  |  |  | ☐ M ☐ F |
| **4.** |  |  |  | ☐ M ☐ F |
| **5.** |  |  |  | ☐ M ☐ F |

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| **If parents are not together, what are the current custody and time sharing arrangements?:** |

**Please list other family members either living in the household or are significant in your child’s life:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Sex** | **Relationship** | **Lives with** |
| **1.** |  | ☐ M ☐ F |  | ☐ Yes ☐ No |
| **2.** |  | ☐ M ☐ F |  | ☐ Yes ☐ No |
| **3.** |  | ☐ M ☐ F |  | ☐ Yes ☐ No |
| **4.** |  | ☐ M ☐ F |  | ☐ Yes ☐ No |
| **5.** |  | ☐ M ☐ F |  | ☐ Yes ☐ No |

***Patient/Family Assessment***

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| **Presenting Problem** |
| **Briefly describe the reason(s) for seeking therapy and the issues that need to be addressed:** |
| **What do you think it would take to improve the situation?** |
| **Have you tried to address the problem in the past? What have you tried and were the changes better or worse?** |
| **Are you court-ordered to seek therapy? ☐ Yes ☐ No**  **If yes, please list agency, attorney, or probation officer’s contact information/case #:** |
| **Family Background** |
| **Are there cultural or religious beliefs that are important to be aware of?** |
| **Please check any past, present, or impending problems/stressors in the family:**  **☐ Physical/Sexual Abuse ☐ Health Concerns ☐ Financial/Unemployment ☐ Frequent Relocations**  **☐ Divorce/Separation ☐ Legal Issues ☐ Emotional/Behavioral Concerns ☐ Deaths**  **☐ Alcohol/Drug Addiction ☐ Eating Disorders ☐ Suicide Ideation/Attempts ☐ Learning Disabilities**  **☐ High Conflict Family Relationships ☐ Incarceration ☐ Emotional/Verbal Abuse**  **☐ Employment ☐ Academic Difficulties ☐ Problems with pornography ☐ Stealing**  **☐ Social Media/Video Game Addiction ☐ Setting Fires ☐ Inappropriate Sexual Behaviors**  **☐ Gambling Addiction**  **If yes, for whom?**  **Please Describe:** |
| **List some of the strengths in your family:** |
| **List some of the weaknesses in your family:** |
| **How does your family deal with conflict?:** |
| **What are things that your family does together on a regular (weekly) basis?:** |
| **Has anyone in your family ever struck, physically restrained, used violence against, or injured any person within the family? ☐ Yes ☐ No**  **If yes, please explain:** |

*History of mental and medical health problems/diagnosis/treatment*

**Please check the symptoms that anyone in the family is currently experiencing:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Symptom** | **Name of Family Member** | **How Long** | **Severity**  ***Mild Moderate Severe*** |
| **Allergies** |  |  |  |
| **Chronic Pain** |  |  |  |
| **Cancer** |  |  |  |
| **Dizziness/Fainting** |  |  |  |
| **High Fevers** |  |  |  |
| **Epilepsy/Seizures** |  |  |  |
| **Thyroid Disease** |  |  |  |
| **Fibromyalgia** |  |  |  |
| **Surgery** |  |  |  |
| **Asthma** |  |  |  |
| **Meningitis** |  |  |  |
| **Diabetes** |  |  |  |
| **Multiple Sclerosis** |  |  |  |
| **Serious Accident** |  |  |  |
| **Headaches or Migraines** |  |  |  |
| **Hearing Problems** |  |  |  |
| **Heart Disease** |  |  |  |
| **Miscarriage** |  |  |  |
| **Abortion** |  |  |  |
| **Stomach Problems** |  |  |  |
| **Head Injury** |  |  |  |
| **Kidney Disease** |  |  |  |
| **Vision Problems** |  |  |  |
| **Sleep Disorder** |  |  |  |
| **Other:** |  |  |  |

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| --- | --- | --- | --- |
| **Mental Health Symptoms** | **Name of Family Member** | **How Long** | **Severity**  ***Mild Moderate Severe*** |
| **Anxiety (worry, fear, tension)** |  |  |  |
| **Depression/Sadness** |  |  |  |
| **Thinking Problems (disorganized, unfocused)** |  |  |  |
| **Uncontrolled Repetition in thinking or behavior** |  |  |  |
| **Mood Swings (change quickly, hard to control)** |  |  |  |
| **Anger or Violent Outbursts** |  |  |  |
| **Grief (feelings of loss, sadness, crying)** |  |  |  |
| **Suicidal Thinking or Actions** |  |  |  |
| **Nightmares/Sleep Disturbances** |  |  |  |
| **Social Isolation** |  |  |  |
| **Panic Attacks** |  |  |  |
| **Trauma** |  |  |  |
| **Emptiness** |  |  |  |
| **Loneliness** |  |  |  |
| **Flashbacks** |  |  |  |
| **Difficulty in Concentrating** |  |  |  |
| **Increased Risky Behavior** |  |  |  |
| **Delusions/False Beliefs** |  |  |  |
| **Hallucinations** |  |  |  |
| **Irritability** |  |  |  |
| **Seasonal Mood Changes** |  |  |  |
| **Obsessive Thoughts** |  |  |  |
| **Impulsivity** |  |  |  |
| **Feeling Worthless** |  |  |  |
| **Phobias** |  |  |  |
| **Changes in Appetite** |  |  |  |
| **Sexual Problems** |  |  |  |
| **Self-Injury/Cutting** |  |  |  |
| **Fatigue** |  |  |  |
| **Loss if Interest/Pleasure in Activities** |  |  |  |
| **Decreased Libido** |  |  |  |
| **Increased Libido** |  |  |  |
| **Excessive Energy** |  |  |  |
| **Crying Spells** |  |  |  |
| **Decreased Need for Sleep** |  |  |  |
| **Suspiciousness/Paranoia** |  |  |  |
| **Avoidance** |  |  |  |
| **Other:** |  |  |  |

**Has anyone in the family been diagnosed with a mental illness?**

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| --- | --- | --- | --- |
| **Name** | **Diagnosis** | **Date of Diagnosis** | **Diagnosed By?** |
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| **Does anyone in your extended family have mental illness?:** |

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| --- | --- | --- | --- |
| **Current prescriptions medications: ☐ None** | | | |
| **Name** | **Medication** | **Date First Prescribed** | **Prescribed By** |
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| **Has anyone in the family currently (or in the past) used any type of drugs, tobacco, or alcohol? If yes, please indicate who, what, and for how long:** |

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| **Please list any previous therapy received by mental health professionals. Include name of family member, name of counselor, name of business, and length of services:** |
| **Has anyone in the family been hospitalized for psychiatric reasons?** |

*Parental Estrangement/Reunification Cases/*

*Court Ordered Divorce Cases Only*

**What effect do you think the estrangement has had on your child(ren)?**

**Are you fearful of your child’s other parent for any reason?**

**Has your child ever witnessed the police being called? If so, what were the circumstances?**

**Has the other parent ever denied you access to your child(ren)?**

**Do you have any concerns about your child(rens) emotional or physical safety with their other parent?**

**When and what are the circumstances of this estrangement?**

**Do you feel that you have contributed to the conflict in the relationship with the child(rens) other parent? If so, how?**

**What do you hope will change through reunification/reintegration therapy?**