Intake Form

Name: _____ Date: _____ Referred by: _____

Home: _____ Cell: _____

Address: _____ City: _____ Zip: _____

Age: _____ Birthdate: _____ Email: _____

Please list how long, to all that applies below:

Married: _____ Partnered: _____ Single: _____ Separated: _____ Divorced: _____ Widowed: _____

Ethnicity: _____ Religion: _____

Name of Emergency Contact: _____ Phone #: _____

Relationship to Client: _____

Are You Currently in Other Counseling? _____ Yes _____ No

If Yes, Name and Address: _____

Prior Counseling, Name(s) & Date(s): _____

_____

Current Medications / Dosages (Including Over the Counter): _____

_____

Have You Had Any Problems with Medications? _____ If Yes, Details: _____

_____

Any Difficulty with Drugs or Alcohol? (Legal, Relational, Occupational or Personal?) _____

_____

_____

Major Reason for Seeking Help at this Time? _____

_____

_____

How long have you had these problems or symptoms? _____

_____

_____

Why did you seek help now? _____

_____

_____

Do You Have Any Serious or Chronic Medical Conditions? _____

_____

If Yes, Dates & Details: _____

_____

Have You Had Any Serious Accidents/Head Injuries/Seizure Activity?

_____

_____

If Yes, Dates & Details:

_____

_____

Do you have any recurring nightmares? (Describe) _____

_____

Who loved you unconditionally from 0 to 18 years of age? Who gave you positive reinforcement? _____

_____

Who loves you and supports you in your life now? _____

_____

What is your spirituality? _____

_____

What spiritual resources do you have, if any? By what name do you call your spiritual supports?

_____

What characteristics do you like most about yourself? _____

_____

Do you have any performance goals you would like to meet? _____

_____

What states of being do you desire to live in or return to? (Peace, Joy, Creativity?) _____

_____

Have you lost any parts of yourself you would really like to have back in your life?_____

_____

THE AMEN CLINIC QUESTIONNAIRE

(0) Never (1) Rarely (2) Occasionally (3) Frequently (4) Very Frequently

____ 1. Frequent feelings of nervousness or anxiety

____ 2. Panic attacks

____ 3. Avoidance of places due to fear of having an anxiety attack

____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)

____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)

____ 6. Tendency to predict the worst

____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)

____ 8. Conflict Avoidance

____ 9. Excessive fear of being judged or scrutinized by others

____ 10. Easily startled or tendency to freeze in intense situations

____ 11. Seemingly shy, timid, and easily embarrassed

____ 12. Bites fingernails or picks skin

____ Total number of questions with a score of 3 or 4 for questions 1- 12 (GAD)

____ 13. Persistent sad or empty mood

____ 14. Loss of interest or pleasure from activities that are normally fun

____ 15. Restlessness, irritability, or excessive crying

____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness

____ 17. Sleeping too much or too little, or early morning waking

____ 18. Appetite changes/ weight loss or weight gain through overeating

____ 19. Decreased energy, fatigue, feeling "slowed down"

____ 20. Thoughts of death or suicide, or suicide attempts

____ 21. Difficulty concentrating, remembering, making decisions

____ 22. Physical symptoms; headaches, chronic pain, digestive problems

____ 23. Persistent negativity or low self esteem

____ 24. Persistent feeling of dissatisfaction or boredom

____ Total number of questions with a score of 3 or 4 for questions 13-24 (MDD)

(0) Never (1) Rarely (2) Occasionally (3) Frequently (4) Very Frequently

____ **25. Excessive or senseless worrying**

____ **26. Upset when things are out of place or don't go according to plan**

____ **27. Tendency to be oppositional or argumentative**

____ **28. Tendency to have repetitive negative or anxious thoughts**

____ **29. Tendency toward compulsive behaviors**

____ **30. Intense dislike of change**

____ **31. Tendency to hold grudges**

____ **32. Difficulty seeing options in situations**

____ **33. Tendency to hold on to own opinion and not listen to others**

____ **34. Needing to have things done a certain way or you become upset**

____ **35. Others complain you worry too much**

____ **36. Tendency to say no without first thinking about the question (OFA)**

____ **Total number of questions with a score of 3 or 4 for questions 25-36**

____ **37. Periods of abnormally happy, depressed or anxious mood**

____ **38. Periods of decreased need for sleep, energetic on much less sleep**

____ **39. Periods of grandiose thoughts and ideas (feeling very powerful)**

____ **40. Periods of increased talking or pressured speech**

____ **41. Periods of too many thoughts racing through your mind**

____ **42. Periods of increased energy level**

____ **43. Periods of poor judgment that leads to risk-taking behaviors**

____ **44. Periods of inappropriate social behavior**

____ **45. Periods of irritability or aggression**

____ **46. Periods of delusional or psychotic thinking**

____ **Total number of questions with a score of 3 or 4 for questions 37 – 46 (BD)**

(0) Never (1) Rarely (2) Occasionally (3) Frequently (4) Very Frequently

____ **47. Short fuse or periods of extreme irritability**

____ **48. Periods of rage without being provoked**

____ **49. Often misinterprets comments as negative when they are not**

____ **50. Periods of spaciness or confusion**

____ **51. Periods of panic or fear for no specific reason**

____ **52. Visual or auditory changes (seeing shadows or hearing sounds)**

____ **53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)**

____ **54. Sensitivity or mild paranoia**

____ **55. Headaches or abdominal pain or uncertain origin**

____ **56. History of head injury or family history of violence/ explosiveness**

____ **57. Dark thoughts, may be homicidal or suicidal**

____ **58. Periods of forgetfulness or memory problems**

____ **Total number of questions with a score of 3 or 4 for questions 47- 58 (TL)**

____ **59. Trouble staying focused**

____ **60. Spaciness or feeling like you're in a fog**

____ **61. Overwhelmed by tasks of daily living**

____ **62. Feels tired, sluggish, or slow moving**

____ **63. Procrastination, failure to finish things**

____ **64. Chronic boredom**

____ **65. Loses things**

____ **66. Easily distracted**

____ **67. Forgetful**

____ **68. Poor planning skills**

____ **69. Difficulty expressing feelings**

____ **70. Difficulty expressing empathy for others**

____ **Total number of questions with a score of 3 or 4 for questions 59-70 (AD)**

Hypomania/Mania Symptoms Checklist (HCL-32, Angst et al 2005)

Try to remember if there was ever a time when you were in a "high" state different from your normal functioning. How did you feel then? Put a check mark next to any that applied during that time or now.

1. ____ I need less sleep
2. ____ I feel more energetic and more active
3. ____ I am more self-confident
4. ____ I enjoy my work more
5. ____ I am more sociable (make more phone calls, go out more)
6. ____ I want to travel and/or do travel more
7. ____ I tend to drive faster or take more risks when driving
8. ____ I spend more money/too much money
9. ____ I take more risks in my daily life (in my work and/or other activities)
10. ____ I am physically more active (sport etc.)
11. ____ I plan more activities or projects.
12. ____ I have more ideas, I am more creative
13. ____ I am less shy or inhibited
14. ____ I wear more colorful and more extravagant clothes/make-up
15. ____ I want to meet or actually do meet more people
16. ____ I am more interested in sex, and/or have increased sexual desire
17. ____ I am more flirtatious and/or am more sexually active
18. ____ I talk more
19. ____ I think faster
20. ____ I make more jokes or puns when I am talking
21. ____ I am more easily distracted
22. ____ I engage in lots of new things
23. ____ My thoughts jump from topic to topic
24. ____ I do things more quickly and/or more easily
25. ____ I am more impatient and/or get irritable more easily
26. ____ I can be exhausting or irritating for others
27. ____ I get into more quarrels
28. ____ My mood is higher, more optimistic
29. ____ I drink more coffee
30. ____ I smoke more cigarettes
31. ____ I drink more alcohol
32. ____ I take more drugs (sedatives, anti-anxiety pills, stimulants)

Credit Card Agreement

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the therapist at your initial session.

CC Type: MC Visa Amex Other _____

Name as shown on card _____

CC Number _____

3-digit security code on back of the card _____

Billing zip code associated with the card _____

Expiration Date _____

This card may be charged for:

Regular session fees (at your request, as a convenience to you)

Fees for cancellation without 24 hours notice (according to PCTC Policy)

Delinquent session fees (fees more than 30 days overdue)

Agreement:

"I _____ (print name) Have read and undersand the terms of providing my credit card information to:
I understand that my credit card may be charged for the reasons indicated above, any questions I have about this practice have been answered.

_____ (Signature) _____ (Date)

INFORMED CONSENT AGREEMENT

California Marriage and Family Therapy, Colleen Cotter LMFT

California Marriage and Family Therapy, Colleen Cotter LMFT is an affiliate of Pacific Trauma Center.

_____ (Initials)

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell us immediately.

We will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

CONFIDENTIALITY:

As part of the counseling process, we are bound by ethical responsibilities to keep confidential the information shared during the sessions and we will not release any information without your written permission. There are important **exceptions to the confidentiality** of the counseling relationship. We are required by law to reveal certain information under the following circumstances:

a) **Disclosure of serious intent to do harm to self or others**
b) **Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse**
c) **If a court of law orders the release of specific information**

APPOINTMENTS:

The length of a usual appointment is 50 –90 minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

CANCELLATIONS AND MISSED APPOINTMENTS:

Cancellation of appointments must be made at least **24 hours in advance**. A credit card number will be taken at the onset of your counseling. Late cancellations will be charged at the regular hourly fee to your credit card. If you have a true emergency your credit card will not be charged.

PAYMENT:

Payment is expected at each session unless other arrangements have been made in advance. You are responsible for payment for all services rendered either by debit card, credit card, check or cash. All checks and credit cards will be paid to _____California Trauma Marriage and Family Therapy, Colleen Cotter, LMFT

THERAPEUTIC TOUCH:

On occasion, and only with your permission, we will use therapeutic touch during trauma therapy sessions. The touch may involve you remaining sitting on your chair or couch and receiving a supportive hand to hold, or the grounding touch of a hand on your shoulder, neck, or back. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual and only happens if you as the client want or need it.

TELEPHONE, TEXT AND EMAIL POLICY:

Generally, we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rates (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE:

We are what is referred to as an "Out of Network Provider." We do not bill your insurance company and payment is due at each session. However, we will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

PHYSICAL EXAMINATION:

We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

TRAINING AND SUPERVISION:

We may provide your therapy by pre-licensed therapists. Your case may be discussed in a group or individual supervision format with a licensed supervisor present for feedback, education, and discussion.

EMERGENCIES:

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Sacramento County Mental Health Crisis Service (phone: 916-875-1000)

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (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.

If you have any questions about our policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read our policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate therapy if you do not comply with the policies or if we feel you are not benefiting from treatment.

Client signature_____Date: _____