# Integrating Mind, Body, Spirit and Community


## Carla Walker LMFT

**661-803-1352**


**INDIVIDUAL INTAKE Clients full Name:**_____

**Address:** _____ **City:** _____ **State:** _____

**Authorization #** _____ **How many sessions** _____ **Deductible met Y or N Policy Holder:** _____ **Relationship to Insured:** _____ **Insured's DOB:** _____ **Policy #** _____ **Group No:** _____

**Insured's SSN:** _____ **Co-Pay Amount: $**_____

**Insured's Employer's Name:** _____**Insured's Employer's Address:**

_____

**Secondary Insurance (if app.):**

_____

**Does your policy cover Psychotherapy: Y / N / Unknown?**

***If your counseling is being paid through an Employee Assistance Program, please list the authorization number and number of sessions authorized: EAP Company:** _____ **Auth No.:** _____ **No. Of Sessions:** _____

**OTHER INFORMATION**

**Significant Other/Spouse:** _____

**DOB:** _____**Address:**

_____

**Employer/Occupation:**_____**Telephone:**_____

**Dependent Information (if app.):**

**Name:** _____ **DOB**_____ **Sex: M / F**

**Name:** _____**DOB**_____ **Sex: M / F**

**Name:** _____**DOB**_____ **Sex: M / F**

**Referred by:**

_____**Email:**_____

**TO BE COMPLETED BY THERAPIST:**

**Procedure Code:** _____ **Primary DX code:** _____ **Secondary DX code:**

**Axis III:** _____**Axis IV:** _____**Axis V:** _____ **Current GAF:** _____

## Strengths assessment (Check all that apply)

**Please check individual items you want to address. Please circle the two most important:**

| | | | | |
|---|---|---|---|---|
| Open to grow | Courageous | Forgiving | Enjoys learning | Creative |
| Walks erect | Calm | Fun | Resourceful | Happy most of the time |
| Up to Date | Decisive | Organized | Keeps your word | Takes things personally |
| Confident | Does your best every day | Financially stable | Does not make assumptions | Friendly |
| Team player | Relaxes | Eats balanced foods | Articulate | Generous |
| Accepting of others | Exercises at least 4X's per week | Marriage Concerns | Improve Communication | Fun |
| Creates Drama | Flexible | Intimacy issues | Career/Job | Concentration |
| Health Problems | Bowel trouble | Shy | Stomach Troubles | Self Esteem Issues |
| Hopelessness | Guilt | Sexual problems/Perform | Temper | Depressed |
| Self Control | Drug use | Harm to self - Suicidal concern | Finances | Impulsivity |
| Abuse alcohol | Harm to others | High energy | Low Energy | Legal Matters |
| Sleep Issues | Repetitive Thoughts | Dreams | Abuse | Memory concerns |
| Educational Needs | Night Mares | Trauma | Nervousness | Anxiety/Panic |
| Poor use of time | Stress | Fears | Unresolved grief | Trauma |
| Jealousy | Physical fighting | Housing | Divorce/Transition | Negative |
| Parenting | Hoarding | Internet Addiction | Infidelity/affairs | Spiritual concerns |
| Weight | Use of time | | | |

**Health Information:**

**List all current medications & vitamins:**

_____

_____

**List all current health problems including allergies:**

_____

_____

**Past psychiatric history (mental health and chemical dependency): hospitalizations (Please Explain)**

_____
_____
_____
_____
_____

**Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, and response to treatment and/or medications:**

_____
_____
_____

**Name of your Primary Care Physician: _____ May we contact? Y/N**

**Phone number: _____ When were you last seen_____**

**I give my consent or do not give consent (circle) for my therapist, _____ to release my records to my primary physician to discuss my treatment:**

**Sign: _____ Date: _____**

**Risk Assessment**

**Suicidal Ideation - None noted Thoughts only Plan Means Attempt**

**Able to contract**

**Homicidal Ideation - None noted Thoughts only Plan Means Attempt Able to contract**

**Drug and Alcohol Assessment;**

**Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? Y /N If yes, self / other and their relationship to you:**

_____

**Frequency of Alcohol use:**

**_____never _____ less than 1 time/month _____1-4 times per month _____ 2-3 times per week _____ daily Usual Alcohol Consumption:**

**_____ never _____ 1-2 drinks per sitting _____3-4 drinks per sitting _____ 5 or more drinks per sitting**

**Frequency of use to levels of intoxication:**

**_____ never _____ 1 time/month _____ 2-4 times per month _____ 2-3 times per week _____ daily**

**Self-perception of alcohol use :( check all that apply)**

**___ Occasional or social ___ Problem use ___ Psychological dependence**

**___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop**

**History of treatment attempts :( check all that apply)**

**___ None ___ Stopped on own ___ Attended AA/ other 12 step program ___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program**

**Other Substance use Assessment: (Check Frequency and Duration)**

**CHOICE AMOUNT**

**Marijuana Sedative Stimulant Cocaine Opiates/Narcotics Inhalants**
**Hallucinogens Caffeine Prescription Meds Tobacco Amphetamines Others:**

**FREQUENCY: _____DURATION: _____ LAST USE: _____**

**Please describe any drug-related problems :( e.g. legal, job, physical, or social)**
**_____**
**Selfperception of Drug Use :( check all that apply)**
**___ Occasional or social ___ Problem use ___ Psychological dependence**

**___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop**
**History of treatment attempts :( check all that apply)**
**___ None ___ Stopped on own ___ Attended NA/ other program**
**___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program**

**List a community resource you are currently benefitting:**
**_____**
**Children and Adolescents:**
**Developmental History (developmental milestones met early, late, normal):**
**_____**

**Peri-natal History (details of labor/delivery):**
**_____**
**Pre-natal History (medical problems during pregnancy, mother's use of medications):**
**_____**

**Risk Factors to Include:**
**Non-compliance with treatment Domestic Violence Eating Disorder AMA/elopement potential Child Abuse Suicidal/Homicidal**
**Prior behavioral health inpatient admissions Sexual Abuse Other: Legal information:**
**Do you have a probation officer or caseworker? If yes, what is his/her Name, Phone number, and Address?**
**Do you have an attorney? If yes, what is her/her Name, Phone number, and Address?**
**Marital Information:**
**Married: ____ Divorced: _____ Living together: _____Separated: _____ Single: _____ If "other" please explain:**

_____
_____

**List dates and lengths of any previous marriages:**

_____
_____

**Write 3 of your beliefs that support your life:**

_____
_____
_____
_____

**When was the last time you accomplished something that made you proud and what did you do?**

_____
_____
_____
_____
_____

**What do you think is getting in your way currently?**

_____
_____
_____
_____

**Client Sign:**_____**Date:**_____

**Therapist:**
_____**Date:**_____

**If you need to reschedule an appointment, 48 hours notice is required. If you have an emergency or illness, you can reschedule with less than 24 hours notice. If you do not show up for a scheduled time, for any reason, and provide no notice (latest notice can be 15 minutes past scheduled session start time) your credit card will be charged 200.00 & we will not make up that time. A credit card is required and processed on the day of missed appointment or if it is agreed as a payment for services. If I need to reschedule, I will give you at least 48 hours notice as well, barring an emergency or illness.**

**Name on Credit Card: _____ Exp date: _____**

**Credit card number: _____**

**Address: _____ Security Code: _____**

**When unable to keep Confidentiality:**

**When there is a reasonable suspicion of abuse to a child, dependent or elder adult.**

**When the client or a credible third party communicates a serious threat of harm to others.**
**When the psychotherapist believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable visit (s)**
**When the therapist has a reasonable belief that the client may be a danger to themselves, others or property of others.**

**• A weekly commitment to therapy is expected unless an emergency or sudden illness. If there are several cancellations you may be referred out unless we are making closure.**

**The Patriot Act of 2001 may require therapists in certain circumstances to provide FBI agents with records and prohibits the therapist from disclosing to the patient that the FBI sought or obtained patient records. When disclosure is otherwise required by law.**

**ADDRESS CHANGES**
**Please advise if you change your address, telephone number, place of employment or insurance coverage or companies.**
**LITIGATION CHARGES**
**If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $200 per hour for me I speak at the legal proceeding.my time, including preparation, telephone, and travel time.**

**Consider someone you know who may benefit from a referral for Counseling or Coaching. It is a wonderful complement. I thank you in advance. I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES.**

_____ _____ _____

**Client** **Date**