

ADULT INTAKE PACKET

(Client fills out in advance)

Name: _____ Date: _____ Referred by: _____

Home: _____ Cell: _____

Address: _____ City: _____ Zip: _____

Age: _____ Birthdate: _____ Email: _____

Please list how long to all that apply below:

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

Ethnicity: _____ Religion: _____

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? _____

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Do you have any serious or chronic medical conditions? If yes, dates & details:

Do you have any chronic pain, recurring body aches, or soreness? Where is your body distress?

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 or source of peace, love or joy?

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?

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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)*

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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)*

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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)*

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Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Check (✓) the answer that best applies to you. Answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family in trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please check 1 response only.</i>		
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? <i>Please check 1 response only.</i>		
<input type="radio"/> No problem <input type="radio"/> Minor problem <input type="radio"/> Moderate problem <input type="radio"/> Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

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INFORMED CONSENT AGREEMENT

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 me immediately.

I 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, I am bound by ethical responsibilities to keep confidential the information shared during the sessions, and I will not release any information without your written permission. There are important exceptions to the confidentiality of the counseling relationship. I am 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 _____ minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished most 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 _____.

CHECKS/OVERDUE ACCOUNTS:

There is a _____ service charge for all checks returned by the bank.

THERAPEUTIC TOUCH:

On occasion, and only with your permission, I may 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, I ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. I encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, my schedule does not permit me 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, I 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 my regular rate (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE:

Services may be covered in full or in part by your health insurance company or employee benefit plan. It is my suggestion that you contact your insurance for questions regarding benefits. I will make every effort to check your benefits prior to your first appointment.

PHYSICAL EXAMINATION:

I 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.

EMERGENCIES:

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the San Diego crisis line at (888) 794-7240. 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 policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read 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: _____

Client signature: _____ Date: _____