Trinity Counseling

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____ _____

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: M F

Who is providing the history information?

___ The patient
___ The patient's guardian
___ Other

Marital Status:

____Never Married ____Domestic Partnership ____Married ____Separated
____ Divorced ____Widowed
Please list any children/age: _____
_____
_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

_____
(Home Phone: (Cell/Other Phone:)

May we leave a message? ___ Yes ____No

E-mail: _____ May we email you? ___Yes ____No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
___ No
___Yes, previous therapist/practitioner:
_____

Are you currently taking any prescription medication? ___ Yes ____No
Please list:
_____

Have you ever been prescribed psychiatric medication? ____ Yes ____No

Please list and provide dates:
_____
_____

EMERGENCY CONTACT INFORMATION
In case of an emergency, who should we contact?

Name: _____

Relationship: _____

Address: _____

Phone Number:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____ What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
▫ No ▫ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
▫ No ▫ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ▫ No ▫ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? ▫ No ▫ Yes

9. How often do you engage recreational drug use? ▫ Daily ▫ Weekly ▫ Monthly ▫ Infrequently ▫ Never

10. Are you currently in a romantic relationship? ▫ No ▫ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

12. Please describe the current complaint or problem as specifically as you can, in your own words.

_____
_____
_____

How long have you experienced this problem, or when did you first notice it?

_____
_____

What stressors may have contributed to the current complaint or problem?

_____
_____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tensions, aches, etc.
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated
[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle:

Alcohol/Substance Abuse Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ▫ No ▫ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes
If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____

4. What do you consider to be some of your weakness?

_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

_____
_____
_____

Electronic Communication Policy and Consent for Treatment

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, the following policy has been prepared. This is because the use of various types of electronic communications is common in our society, and many individuals prefer this method of communication. This does put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy as been prepared to assure the security and confidentially of your treatment and to assure that it is consistent with our ethics and the law.

If you have questions regarding this policy, please feel free to discuss this with me.

_____ **Email Communications**

My office staff may use email communication and text messaging only with your permission and only for administrative purposes unless we have made other agreements. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues.

Email is not a secure form of communication so I will not respond in any detail to emails regarding clinical matters, such as treatment questions. If you need to discuss a clinical matter with me, please feel free to call me and we can discuss it on the phone or wait until we have our next session.

_____ **Text Messages**

Communication by text messages is insecure. Please use text messaging for issues such as, changing or confirming appointments. Any other messages I will respond by asking you to call me.

_____ **Minors**

If you are under the age of eighteen, please be aware that the law may provide your parents or legal guardian(s) the right to examine your treatment records. It is my policy to request an agreement from parents or legal guardian(s) that I provide then only with general information about our work together, unless I feel there is a high risk you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will provide them with a summary of your treatment upon their request. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

_____ **Divorce**

If you have been or are not going through a divorce, please understand that, legally, I am not a part of the divorce and am not bound to any divorce decree issued by a court of law. The person who presents him/herself or a minor for treatment is responsible for paying the treatment bill. If your divorce decree that an ex-spouse is to pay any portion

of the treatment bills, you must pay me at the time of service and then seek payment from your ex-spouse per terms of your divorce decree.

All parents or legal guardian(s) need to consent for treatment with a minor child. I will need the names, address and phone numbers for these adults. I will also need all parents or legal guardian(s) to all relevant paperwork. If a parent states he/she has sole custody/guardianship of a minor child, that parent will need to bring that paperwork from the court that verifies this. I encourage all parents or guardian(s) to be present for the initial session for minor children. Attendance and/or parent/guardian participation in follow up sessions with vary depending on the treatment plan.

_____ **Consent for Treatment**

You voluntarily consent to receive services which any include any or all of the following: individual, group or family therapy; crisis intervention; and referral recommendations deemed necessary and advisable in the judgment of Nicole Rojas, p-LPC. If the client is a minor child or otherwise incapable of providing consent to the same services for him/her. You have the right to accept, refuse or stop treatment at any time.