Highest Heights Individual and Family Therapy
General Information

Client's full name and names of family members living in the household:

Name	Date of Birth	Family Role	Social Security Number

Street Address (physical address): _____

City: _____ State:_____ Zip Code: _____

Mailing Address (if different than street address): _____

City: _____ State:_____ Zip Code: _____

Telephone Numbers: May I identify myself and leave a message?

		YES	NO
Home:			
Work:			
Cell:			
Other:			

Emergency Contact: Name:_____ Relationship:_____ _____ Phone Number: _____

I give permission for this person to be contacted by Highest Heights Individual and Family Therapy in case of an emergency.

Initials: _____

How did you find me? (please circle all that apply) Psychologytoday.com General Online Search Yellow Pages

Word of Mouth Business Card (Location of business card: _____)

Direct Referral (Referred by:_____)

For demographic purposes only:

Relationship Status: (please circle) Married Single Widowed Divorced Separated Cohabiting Other: _____

Ethnicity: (please circle) African-American Asian Caucasian Hispanic Other: _____

Employment Status: (please circle) Student Part-Time Full-Time Unemployed Disabled

Intake Form

Client Name: _____ **DOB:** _____

1. Physical Health History:

Primary Doctor: _____ Telephone number: _____

Check all that apply:

□ NONE □ fibromyalgia □ cardiac event □ recent illness: _____
□ diabetes □ migraines □ stroke □ surgery: _____
□ thyroid disorder □ asthma □ traumatic brain injury □ medication allergies: _____
□ other: _____

Medication Log: Please let me know if you need additional space.

Medication	Dosage	Frequency	Prescribed by:	Effective?
Do you take your medication regularly and as prescribed? □ NO □ YES				

2. Mental Health History:

Have you ever been to therapy before? □ NO □ YES, where? _____
when? _____

Psychiatrist: _____ Telephone number: _____
Have you seen the psychiatrist in the last 6 months? □ NO □ YES

History of ER visits or hospitalization for mental health treatment: □ NO □ YES
Total admissions: _____ Hospitalized in the last 2 years? □ NO □ YES
Facility: _____ Approximate Dates of Treatment: _____
Facility: _____ Approximate Dates of Treatment: _____

Do you have a family history of any mental health issues: □ NO □ YES, explain:
_____
_____

3. Legal History:

Are you experiencing any legal problems at this time? □ NO □ YES, explain:
_____
_____

Are you court ordered for treatment: □ NO □ YES, agency & case worker/officer: _____

Are you or your family involved with a DSS case? □ NO □ YES, case worker: _____

Are you currently applying for disability or do you plan to apply in the future? □ NO □ YES

4. Concerns:

List the problem(s) you want help with in therapy. For each problem you identify, please list ***when the problem began*** and ***how distressed*** you have felt by that problem.					
Problem	When it began	Distress Level			
		A little	**Moderate**	**Quite a bit**	**Extreme**
		1	2	3	4
		1	2	3	4
		1	2	3	4
		1	2	3	4

On the following checklist, please indicate problems that are a concern to you about ***YOURSELF***:

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ anger
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ sexual abuse/rape
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision making
- ❑ feeling "stuck"
- ❑ changing in eating habits
- ❑ changing in sleeping patterns
- ❑ changes in motivation or interesting in doing things you'd normally enjoy
- ❑ other (please specify):

_____
_____
_____

Problems that are a concern to you about ***YOUR PARTNER***:

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ anger
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ sexual abuse/rape
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision making
- ❑ feeling "stuck"
- ❑ changing in eating habits
- ❑ changing in sleeping patterns
- ❑ changes in motivation or interesting in doing things you'd normally enjoy
- ❑ other (please specify):

_____
_____
_____

Problems that you experienced ***BEFORE AGE 18***:

- ❑ alcohol/drug addiction
- ❑ physical abuse
- ❑ emotional/verbal abuse
- ❑ unwanted touching
- ❑ financial problems
- ❑ sexual abuse
- ❑ divorce
- ❑ emotional distance
- ❑ other (please specify):

_____
_____
_____

Substance Use:

In general, how often do you drink alcohol?

- ❑ Never
- ❑ Less than once a month
- ❑ About once a week
- ❑ Several days per week
- ❑ Daily

Do you drink more now than you used to? ❑ Yes ❑ No

Has anyone objected to your drinking? ❑ Yes ❑ No

Are you using or have you recently used street drugs? ❑ Yes ❑ No

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Problems that are a concern to you about ***YOUR RELATIONSHIP***:

- ❑ poor communication
- ❑ argue about finances
- ❑ not enough time together
- ❑ too much time together
- ❑ fighting/arguing
- ❑ physical violence
- ❑ excessive alcohol/drugs
- ❑ refuses sex too often
- ❑ demands sex too often
- ❑ physical sexual problems (impotence, painful intercourse, etc.)
- ❑ parenting differences
- ❑ partner too controlling
- ❑ different values
- ❑ emotional abuse
- ❑ difficulties with in-laws/extended family
- ❑ other (please specify):

_____
_____
_____

Problems that are a concern to you about your ***CHILDREN/FAMILY***:

- ❑ behavior problems
- ❑ drugs/alcohol
- ❑ adolescent pregnancy
- ❑ ADD/ADHD symptoms
- ❑ sexual abuse
- ❑ anxiety
- ❑ depression
- ❑ anger
- ❑ death in family
- ❑ divorce adjustment
- ❑ peer relationships
- ❑ poor self-esteem
- ❑ bed-wetting/soiling
- ❑ destructiveness
- ❑ issues with step-children/step-parenting
- ❑ eating disorder
- ❑ self-injury/self-mutilation
- ❑ other (please specify):

_____
_____
_____

ACE Survey (Adverse Childhood Experiences)

Are you interested in addressing your traumatic life experience(s) during the course of therapy: □ yes □ not at this time

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?
   No___If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: _____ This is your ACE Score

Taken from: http://acestoohigh.com/got-your-ace-score/ Please see this website for more information on the ACE Study.

Are there any other trauma experiences you are interested in sharing or working on in therapy?

_____

_____

_____

_____

_____

Limited Waiver of Confidentiality
(Members involved in care)

I _____ consent to allow Henry Anderson at Highest Heights Individual and Family Therapy to:

- contact the people/institutions listed below
- acknowledge my involvement in therapy to these people/institutions
- discuss with these people/institutions specific information revealed during therapy sessions
- discuss with these people/institutions any clinical opinions, diagnostic impressions, and treatment plans with regard to my participation in therapy
- send occasional Clinical Notification letters to the people/institutions listed below in an effort to improve my overall care

Family Doctor: _____Phone#: _____

Pediatrician: _____Phone#: _____

Psychiatrist: _____Phone#: _____

School Counselor: _____Phone#: _____

Other Members of Client Care: _____Phone#: _____

_____Phone#: _____

Any and all exceptions that pertain to this waiver are explicitly and completely noted below:
_____
_____
_____
_____
_____
_____
_____
_____

By signing below, I acknowledge that I

- understand the nature of this waiver of confidentiality
- have willingly completed this contract
- maintain the right to change or nullify any/all of the terms of this contract at any time

Client name (printed): _____

Client signature: _____

Date: _____

Confidentiality

Although shared personal information is confidential, there are exceptions to these confidences set by my professional code of ethics and by the law:

1. I must report what is mandated by law, such as child or elder abuse.
2. I must report if there is a clear and present danger to a person or persons such as threat of suicide or homicide.
3. I may share specific information if I have a signed waiver from each participant in therapy.
4. I must disclose if I believe your mental/emotional condition makes you unable to take care of yourself or people for whom you are responsible.
5. I must disclose if it is determined that you are in need of hospitalization.
6. I must share if I am ordered by a court judge to do so.
7. I may disclose information in order to defend myself against charges arising from therapy. I am subject to subpoena.

Confirmation and Consent

My signature indicates that:

- All of the information I have given is accurate to the best of my knowledge.
- I have been given a copy of the "IMPORTANT INFORMATION FOR CLIENTS" packet which includes:
  - disclosure statement
  - notice of privacy practices
  - rights regarding my health information
  - general information
  - emergency contact information
- I have read and understood the limits to confidentiality.
- I have been given the opportunity to ask any questions I might have regarding this information.
- I consent to treatment by Highest Heights Individual and Family Therapy.

Client: _____ Date: _____

Client: _____ Date: _____

Continued Contact

My signature indicates my authorization for Highest Heights Individual and Family Therapy to occasionally mail items such as satisfaction surveys, newsletters, etc. to my home address. I understand that I can request the cancellation of mailing materials to my home at any time.

Client: _____ Date: _____

Therapist: _____ Date: _____