DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

Before I can ask you to give me any information I am required by law to explain who can see it and how it will be used. The information you give will be used to help determine the kind of treatment you need. No law requires that you give me information, but I cannot help you without some information.

Home Phone: _____ ☐ messages OK ☐ NO MESSAGES
Cell Phone: _____ ☐ messages OK ☐ NO MESSAGES
Email Address: _____ ☐ messages OK ☐ NO MESSAGES
Emergency Contact: _____ Phone number: _____

REFERRAL INFORMATION:

- Referral source:
- What challenge(s) would you like to overcome?

- How long have you been experiencing these challenge(s)?

GENDER: _____

ETHICITY: (Choose as many as applicable.)

☐ White ☐ Asian, Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ American Indian or Alaska Native
☐ Other:_____

TRANSPORTATION:

☐ Drive Self ☐ Car Make/Model/Color: _____
☐ Bus
☐ Other: ☐ License Plate Number: _____

FAMILY HISTORY

Born in: Raised in:		Who raised you?
Childhood household members	Relationship to client	Quality of relationship

1. Was your birth planned? ☐ Yes ☐ No ☐ Don't know (Dk)
2. Were there any complications with pregnancy or your birth? ☐ Yes (explain) ☐ No ☐ Dk
3. Was your mother in poor physical or emotional health? ☐ Yes ☐ No ☐ Dk
4. Did she experience any losses or dramatic events during her pregnancy with you? ☐ Yes (explain) ☐ No ☐ Dk
5. Were you adopted? ☐ Yes ☐ No
6. Did your family have adequate food, shelter, and other basic needs met? ☐ Yes ☐ No (explain)
7. Did you feel loved? ☐ Yes ☐ No (explain)
8. Were your parents: ☐ Married ☐ Living together ☐ Unmarried but in a relationship together ☐ Divorced ☐ Separated ☐ Remarried ☐ Other:
9. How many places did you live while growing up?

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

10. Were you separated from either parent or siblings for a lengthy period? ☐ Yes (explain) ☐ No
(If yes, where and with whom did you live then?)

11. Did your parents/primary caregivers fight? ☐ No ☐ Verbally ☐ Physically ☐ Witnessed these fights

12. Were there any other relationships coming into the home? ☐ Yes (explain) ☐ No

13. Where are you in the birth order?

14. Did you have any serious fights with your siblings? ☐ Yes (explain) ☐ No

15. Do you have any ongoing difficulties with siblings? ☐ Yes (explain) ☐ No

16. Describe the values you learned growing up in your family:

17. Describe what it was like growing up in your family:

FAMILY HISTORY OF MENTAL ILLNESS:

Is there a history of substance abuse, addictions or psychiatric illness in your family?

- ☐ Yes (Describe family member(s) by name and symptoms.) ☐ No ☐ Dk

- ☐ Yes (Explain and describe the impact this had on you.) ☐ No ☐ Dk

1. Please list any **information that you believe will be helpful** for your therapist to know.

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

CURRENT LIVING SITUATION AND SUPPORT SYSTEM

My Home: ☐ Rent ☐ Own ☐ Other (explain) _____

Current Household Member Names	Relationship to Client	Age	Quality of Relationship

1. Who provides you with strength and hope?

2. Is your family supportive of you? ☐ Yes ☐ No Describe:

3. Are you in a significant relationship with someone at present? ☐ Yes (Describe) ☐ No
(Describe relationship and your level of satisfaction with the relationship)

4. Is it easy for you to develop and maintain romantic relationships? ☐ Yes ☐ No (explain)

5. Is your current living environment safe ☐ Yes (explain) ☐ No
(Please include any alcohol or other drug use, disordered eating behavior, other addictive or disturbing behavior)

SIGNIFICANT FRIENDS/FAMILY MEMBERS/OTHERS NOT LISTED ABOVE

Others	Relationship to Client	Age	Quality of Relationship

- Is it easy for you to make and keep friends? ☐ Yes ☐ No (explain)

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

EDUCATION HISTORY (check all that apply):

☐ High School Graduate or Highest Grade Completed:	☐ GED	☐ Vocational School
☐ College/University Number of years, quarters or semesters completed: Degree/Major:	☐ Higher Education:	Comments:
1. Was school a positive or negative experience for you? 2. Did you feel teased, tormented, bullied, or threatened in school? ☐ Yes (explain) ☐ No 3. Did you feel excluded, outcast, or ostracized in school? ☐ Yes (explain) ☐ No		

***History of Learning Difficulties**:* ☐ none reported
☐ Learning disability/type: _____
☐ Mental retardation IQ, if known: _____
☐ Special school placement: _____
☐ Other: _____

***Barriers to Learning*:** ☐ None reported
☐ Inability to read or write ☐ Other: _____
☐ See also records from: _____

How do you learn best?
☐ Visual (spatial): Prefer using pictures, images, and spatial understanding
☐ Aural (auditory-musical): Prefer using sound and music
☐ Verbal (linguistic): Prefer using words, both in speech and writing.
☐ Physical (kinesthetic): Prefer using your body, hands, and sense of touch
☐ Logical (mathematical): Prefer using logic, reasoning and systems.
☐ Social (Interpersonal): Prefer to learn in groups or with other people.
☐ Solitary (Intrapersonal): Prefer to work alone and use self-study.

EMPLOYMENT (check all that apply)

☐ Full time (35 hours or more per week)
☐ Part time (<35 hrs per week)
☐ Non-competitive / not gainful
☐ Volunteer
☐ Unemployed / date last worked: _____
☐ Not in labor force: ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Living in institution ☐ Other: _____

If employed, name of employer: _____
Number of jobs in last 5 years: _____

JOB PERFORMANCE HISTORY

Attendance: ☐ Above average ☐ Normal ☐ Tardiness ☐ Absenteeism

Performance: ☐ Exemplary ☐ Good ☐ Average ☐ Below average

Employment interests / Skills:
Are you satisfied with current job? ☐ Yes ☐ No
Would you like to work (if not currently employed)? ☐ Yes ☐ No
Are you experiencing financial problems? ☐ Yes ☐ No
Are you concerned that employment will affect benefits? ☐ Yes ☐ No

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

Comments on past or current employment / education skills / interests:

FINANCIAL HISTORY

Responsibility: ☐ extremely frugal ☐ budget-focused ☐ impulsive-spender/no budget

MILITARY HISTORY

Military History: ☐ none reported ☐ Navy ☐ Army ☐ Marines ☐ Air Force Trauma ☐ Y ☐ N Describe any pertinent duties:
Type of discharge: Date of Discharge:

MENTAL HEALTH TREATMENT HISTORY

- Outpatient mental health treatment: ☐ none reported / Previous or Current diagnosis: ☐ not known by client

Agency	Dates of Service / Current	Clinician Name

- Psychiatric Hospitalizations: ☐ none reported

Most Recent Hospitalizations	Dates of Service	Reason (suicidal, depressed, etc.)
Total # of hospitalizations:		

EATING HISTORY

1. Have you ever struggled with food or eating? ☐ Yes ☐ No (If yes, what age did this start?) _____
2. Are you preoccupied with your weight? ☐ Yes ☐ No
3. Are you preoccupied with foods, menus, recipes? ☐ Yes ☐ No
4. What was your highest weight: _____ lowest weight:_____ current:_____ height:_____
5. Have you used any of these methods to control weight? ___ Dieting ___ Fasting ___ Amphetamines ___ Cocaine ___ Exercise ___ Vomiting ___ Laxatives ___ Diet pills ___ Diuretics ___ Other Methods: _____
6. Do you have a history of binging and/or purging ☐ Yes ☐ No If yes, what age did it start? _____
7. Do you binge on certain foods? ☐ Yes ☐ No If yes, what _____
8. I have eating habits that are different from those of my family and friends.
   ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
9. I can't go through the day without worrying about what I will or will not eat.
   ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
10. I prefer to eat alone or when I'm sure that no one will see me. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

11. I make excuses (e.g. "I already ate", "I am not feeling well", etc.) so that I will not have to eat with friends and family. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
12. I have uncontrollable periods of eating during which I consume large amounts of food and afterwards I make myself vomit. ☐ Never ☐ Less than once a week ☐ 1 – 6 times a week ☐ Once or more a day
13. I find myself cutting up my food into tiny pieces, hiding food so people will think I ate it, chewing it and spitting it out without swallowing it and/or keeping hidden stashes of food. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
14. I have determined that there are certain "safe" foods that are okay for me to eat, and "bad" foods that I refuse to eat. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
15. I become angry when others show interest in what I eat and pressure me to eat more.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
16. I am afraid that no one would understand my fears about food and eating, so I keep these feelings to myself.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
17. I enjoy cooking gourmet meals and/or high calorie foods for others, but I would never eat them myself. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
18. I go through long periods of time without eating (fasting) or eating very little as means of weight control.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
19. My friends tell me that I am thin, but I do not believe them because I feel fat.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
20. I would panic if I got on the scale and found out that I had gained weight.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
21. I use laxatives or diuretics as a means of weight control. ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
22. I have an overwhelming fear of gaining weight. ☐ Yes ☐ No
23. I exercise excessively to try to lose weight and I become anxious if I miss a workout. ☐ Yes ☐ No
24. It is very important that I am thinner than all of my friends. ☐ Yes ☐ No
25. I am unable to maintain a weight that is considered healthy and consistent with my build, age and height.

    ☐ Yes ☐ No
26. (Females only) My menstrual period has stopped or become irregular due to no known medical reasons.

    ☐ Yes ☐ No
27. When was your last period? _____ How long did it last? _____

    Intensity of flow ☐ light ☐ moderate ☐ heavy
28. (Females only) Have you ever missed any periods? ☐ Yes ☐ No (If yes, how long (months/years)?
29. I can spend hours reading books or magazines about dieting, exercising, fitness, or calorie counting.

    ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
30. I have felt depressed and irritable lately, and spend most of my time alone. ☐ Yes ☐ NoI tend to be a perfectionist; I am not satisfied unless things are perfect. ☐ Yes ☐ No
31. **Please describe current disordered eating and relevant behaviors:**

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

SAFETY ISSUES

Self-injury: ☐ None reported ☐ Cutting ☐ Burning ☐ Scratching ☐ Other:
Frequency: ☐ Monthly ☐ Weekly ☐ Daily / *Requires medical attention (current or by history)*: ☐ None reported
Current suicidal thoughts/urges: ☐ None reported ☐ Ideation ☐ Plan ☐ Access/Means ☐ Intent
Suicidal history: ☐ None reported ☐ Number of attempts: _____
Current homicidal thoughts/urges: ☐ None reported ☐ Ideation ☐ Plan ☐ Access/Means ☐ Intent
Homicidal history: ☐ None reported ☐ Number of attempts: _____
Impulse control: ☐ Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive
Hallucinations: ☐ Yes, describe _____ ☐ Current ☐ Past ☐ No
Delusions: ☐ Yes, describe _____ ☐ Current ☐ Past ☐ No

CURRENT SYMPTOM CHECK – IN (Rate on a scale of 0-10 with 10 being the worst: please **circle** how you feel today **AND** place a **square** around the number for the average of how you have felt over the last month).

Depression: 0 1 2 3 4 5 6 7 8 9 10 (very depressed)
Anxiety: 0 1 2 3 4 5 6 7 8 9 10 (highest anxiety)
Suicidal Ideation (thoughts of killing yourself): 0 1 2 3 4 5 6 7 8 9 10 (highest intention)
Self-Injurious urges to harm yourself via cutting, burning, etc): 0 1 2 3 4 5 6 7 8 9 10 (highest)
Energy: 0 1 2 3 4 5 6 7 8 9 10 (highest level of energy)
Ability to concentrate: 0 1 2 3 4 5 6 7 8 9 10 (highest level of concentration)
Feelings of hopelessness: 0 1 2 3 4 5 6 7 8 9 10 (highest hopelessness)

SEXUAL HISTORY

Comfortable to discuss these issues today ☐ Yes ☐ No ☐ At a later time in therapy

- Are you sexually active? ☐ Yes ☐ No
- Age at which you became sexually active: _____
- Number of sexual partners in the last 12 months: _____ Number of sexual partners in your lifetime: _____
- Is sex mechanical or emotional?
- Are you currently in a sexual relationship? ☐ Yes ☐ No Are you satisfied with this relationship? ☐ Yes ☐ No
- Would you describe yourself as:
  ☐ Heterosexual ☐ Heterosexual with some same sex-attraction ☐ Bisexual
  ☐ Gay ☐ Lesbian ☐ Gay/Lesbian with some opposite sex attraction
  ☐ Asexual ☐ Transgender ☐ Questioning
- Have you ever been bullied, physically or emotionally harmed because of your sexuality? ☐ Yes ☐ No ☐ If yes, describe:
- Have you ever been forced or coerced to have sex? ☐ Yes ☐ No ☐ Not sure
- Do you need alcohol or other drugs to feel comfortable having sex? ☐ Yes ☐ No
- Have you paid or exchanged sex for money, alcohol or other drugs? ☐ Yes ☐ No
- Have you ever been diagnosed with a sexually transmitted disease/infection (STD/SDI)? ☐ Yes ☐ No
  If yes, what (if comfortable disclosing):

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

TRAUMA HISTORY (*See Life Events Checklist and PTSD Checklist)*

Comfortable to discuss these issues today ☐ Yes ☐ No ☐ At a later time in therapy

1. What are the three most traumatic things you have experienced?
   a.
   b.
   c.
2. Have you experienced the loss of a pregnancy? ☐ Yes ☐ No
3. Have you experienced a loss of home? ☐ Yes ☐ No If yes, what circumstances:
4. How did/does your family handle grief/loss?
5. Are there any unresolved feelings of grief/loss that you would like help resolving?

ABUSE HISTORY

(When comfortable please share further descriptions with therapist)

☐ no reported history of abuse/violence	☐ emotional abuse
☐ physical abuse	☐ elder abuse
☐ domestic violence/abuse	☐ sexual abuse/molestation
☐ community violence	☐ other:
☐ physical neglect	

Reported? ☐ Yes (please explain) ☐ No

MEDICAL HISTORY (include allergies and infectious diseases):

1. Do you have any current medical problems? ☐ Yes (describe) ☐ No
2. Do you have any allergies? ☐ Yes (describe) ☐ No
3. PCP name and phone #: Date of last exam:
4. Dentist name and phone #: Date of last exam:
5. (Females only) OB-GYN name and phone #: Date of last exam:
6. List alternative treatments / therapies you have had: (i.e. biofeedback, acupuncture, hypnosis, etc):
7. Have you had any hospitalizations, surgery, or serious illness? ☐ Yes (describe) ☐ No
8. Have you had any long-term or difficult medical treatments? ☐ Yes (describe) ☐ No
9. Have you had any life-threatening conditions? ☐ Yes (describe) ☐ No
10. Have you had any accidents (burns, falls, broken bones, auto, etc)? ☐ Yes (describe) ☐ No

11. Have you had difficult experiences with doctors, nurses, or hospitals? ☐ Yes ☐ No (If yes, how did you respond)

12. Have you experienced chronic, unexplained physical ailments? ☐ Yes ☐ No (If yes, what was going on in your life when symptoms were first apparent?)

13. Do you have trouble falling asleep? ☐ Yes ☐ No

14. Do you have trouble staying asleep? ☐ Yes ☐ No

15. How many hours of sleep do you typically get? _____

CURRENT MEDICATIONS

Name	Dose Frequency	Prescribed by	For what Condition	Compliant Yes/No	Method

PAST (WITHIN PAST 6 MONTHS) MEDICATIONS:

Name	Dose Frequency	Prescribed by	For what Condition	Compliant? Yes/No	Method

ALCOHOL/DRUG HISTORY

☐ Illegal drug use/abuse in past 12 months
☐ Prescription drug use/abuse past 12 months
☐ Non-prescription drug use/abuse past 12 months
☐ Alcohol abuse past 12 months
☐ Alcohol/drug use/abuse previous to past 12 months (see comments)

Drug/Substance/Alcohol/Tobacco	Age Of First Use	Date Of Last Use	Amount/ Frequency Of Use	Amount Used in Last 24 hours	Method
Alcohol					
Amphetamines					
Barbiturates					
Caffeine					
Crack Cocaine					
Cocaine					

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

Drug/Substance/Alcohol/Tobacco	Age Of First Use	Date Of Last Use	Amount/ Frequency Of Use	Amount Used in Last 24 hours	Method
Hallucinogens					
Inhalants					
Marijuana					
Methadone					
Methamphetamine					
Nicotine					
Opiates					
Prescription Medication					
Sedatives					
Tranquilizers					
Over-the-counter Medication					
Other, please identify					

Alcohol and Drug Treatment: ☐ none reported
Current: ☐ OP ☐ IOP ☐ Hospital ☐ Residential ☐ Other: _____
Past: ☐ OP ☐ IOP ☐ Hospital ☐ Residential ☐ Detox ☐ Other: _____

If current or past complete the following:

Name Of Provider/Agency	Type Of Service	Date Of Service

1. Do you have a history of withdrawal, DTs, blackouts (loss of time), seizures, etc? ☐ Yes ☐ No ☐ If yes, explain:
2. Have you developed a tolerance to alcohol or other drugs? ☐ Yes ☐ No ☐ If yes, explain:
3. What is the longest period of sobriety you've ever had? Date:

LEGAL HISTORY

History of legal charges: ☐ None reported
☐ Juvenile: ☐ Status offense (e.g. unruly) ☐ Delinquency
☐ Adult: ☐ Misdemeanor ☐ Felony
Current Legal Status: ☐ None reported
☐ Probation ☐ Detention ☐ Parole ☐ Awaiting charge ☐ Conditional release
☐ A/D related legal problems ☐ Civil commitment / Stay of commitment
☐ Court ordered to treatment

1. List and date legal charges from the past five years:
2. Will you require a letter from your therapist to legal authorities? ☐ Yes ☐ No If yes, please provide contact information:
3. Convictions: ☐ none reported
4. Incarcerations: ☐ none reported
5. Name and phone number of probations/parole officer (if applicable):
6. Civil proceedings: ☐ none reported
7. Domestic relations court problems (i.e., custody, protective services, restraining order): ☐ none reported
8. Juvenile court involvement (related to child abuse, neglect, or dependency): ☐ none reported
   Current: Past:

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

SNAP

List 3 Strengths: _____

List any Needs you currently have: _____

List 3 Abilities: _____

List any Preferences you have regarding treatment: _____

Cultural issues / special needs: ☐ none reported

- ☐ Language: _____
- ☐ Cultural/spiritual/religious: _____
- ☐ Gender: _____
- ☐ Ethnic: _____
- ☐ Other: _____

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

Please indicate which items below you experience or have difficulty with by indicating either **C for Current** and/or **P for past**. Please add missing symptoms to the list under **"other concerns or issues"** and include clarifying details if needed.

	Abortion		Grieving, mourning		Physical problems
	Abuse - emotional		Guilt		PMS
	Abuse - neglect		Headaches, pains		Poor self-care
	Abuse - sexual		Health, illness		Pornography use
	Adoption		Hearing voices		Procrastination
	Aggression		Hostility		Relationship problems
	Alcohol Use		Hyperactivity		Relaxation
	Ambition		Impulsive spending		Re-marriage
	Anger		Impulsiveness		Risk-taking
	Anxiety		Incest		Sadness
	Arguing		Indecision		School problems
	Attention problems		Inferiority feelings		Self abuse - burning
	Career concerns		Infertility		Self abuse - cutting
	Childhood issues		Inhibitions		Self abuse - other
	Children – care of		Interpersonal conflicts		Self abuse - scratching
	Children - custody		Irresponsibility		Self abuse – pulling hair out
	Children - management		Irritability		Self-centeredness
	Choices I've made		Judgment problems		Self-control
	Chronic pain		Laziness		Self-esteem
	Codependence		Legal matters, charges, suits		Self-neglect, poor self-care
	Communication		Loneliness		Separation
	Compulsive spending		Loss of control		Sexual addiction
	Confusion		Losses		Sexual conflicts
	Constant conflicts		Loss of interest in activities		Sexual desire differences
	Crying		Loss of interest in sex		Shyness
	Deaths		Low energy		Smoking
	Debt		Low frustration tolerance		Spirituality
	Decision making		Low income		Step-parenting
	Dependence		Low mood		Stress
	Depression		Marital conflict		Stress-management
	Distractibility		Marital distance		Suspiciousness
	Divorce, separation		Marital infidelity/affairs		Temper problems
	Domestic violence		Medical concerns		Tension / stress
	Drug abuse – over the counter		Memory problems		Thought disorganization
	Drug abuse - prescription		Menopause		Threats of violence
	Drug abuse – street drugs		Menstrual problems		Tiredness
	Drug abuse - alcohol		Mixed feelings		Tobacco use
	Education		Mood swings		Unhappiness
	Employment – lack of		Motivation		Violence
	Employment - overdoing		Mourning		Violence – victim of crime
	Employment problems		Nail-biting		Weight and diet issues
	Employment - termination		Nervousness		Withdrawal - isolating
	Emptiness		Nightmares		Work problems
	Exhaustion		Obsessions, compulsions		Worry all the time
	Failure		Outbursts		*Insulin abuse*
	Fatigue, low energy		Oversensitive to criticism		
	Fears, phobia		Oversensitive to rejection		
	Feelings of helplessness/hopeless		Overweight		
	Financial troubles		Panic or anxiety attacks		
	Friendship problems		Parenting		
	Gambling		Perfectionism		
	Gender identity		Pessimism		**Other concerns or issues:**
	Goals not being met		Phobias		

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

Welcome! Thank you for choosing me as your therapist. This is an opportunity to acquaint you with information relevant to therapy, payment arrangements, and office policies. I will be glad to answer any questions you have regarding any of these policies.

Clients Rights and Responsibilities:
Please read the following policy statements and sign your initials and date on the line after each paragraph to acknowledge you understand each section. Each item will be reviewed for clarity during the initial session and all questions are welcomed and encouraged!

Benefits and risks of therapy: The benefits of therapy could lead to better relationships, solutions to specific problems, and significant reduction of distress. Since therapy involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings from time to time. There are no certainties with regard to what your particular experience will be. Your active participation in the process is essential to reaching your goals. The major goal of therapy is to help you identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strengths.
2. Taking personal responsibility to make the changes necessary to attain your goals.
3. Identifying specific therapy goals.
4. Utilizing all available community, medical, and self-help resources. _____

Confidentiality - therapists have an ethical and moral obligation to keep privileged information confidential. Exceptions to this rule, whereby therapists may breach confidentiality is eminent danger to the client or other person such as a vulnerable adult, suspected child or elder abuse, or domestic violence where a report is filed with the proper authorities to ensure the safety of client and others. Otherwise, information will only be released with the client's written permission unless the client is under the age of 18. _____

Using your Insurance Benefits
I am not an "in-network provider" for any insurance plans, so I do not bill your insurance company. However, many insurance plans include "out-of network" benefits that will reimburse you for some part of your fee after meeting a deductible amount. For reimbursement, insurance companies require therapists to submit a mental health diagnosis that may hinder certain employment if mental health records are part of the background check. I can provide you with a fee statement that you can submit to your insurance company for reimbursement of out-of-network services under the terms of your plan. You can find out the specific terms of your out-of-network benefits by contacting the customer service department on the back of your insurance card. _____

Fees and Appointments – sessions are 50-60 minutes unless longer is requested or required dependent on the therapeutic modality. Sessions are $100.00/hour; however, in-take sessions are 90 minutes in length and $150.00. Scheduled phone sessions are also available to current clients under special circumstances. Clients will receive a courtesy reminder of their appointment through text or email._____

Cancellations – clients are billed full fee for no-shows or appointments not cancelled 24 hours in advance though emergencies/illness are honored and no fee is charged. Too many emergencies or last minute cancellations will be billed full fee and addressed to better understand the underlying cause so we can work together to find a solution.
_____

Phone Calls & Emails – phone calls and emails are limited due to the therapist's need for self-care and to keep regular business hours. Contact outside of scheduled sessions could be construed as unscheduled therapeutic sessions and incur charges. Response to quick emails/voice mails usually concerning scheduling or homework clarification is usually within 24 hours. If there is an emergency, call the crisis hotline at 615-244-7444 or head to your nearest emergency room._____

Credit Card Authorization for Recurring Fees
By signing below, I hereby authorize Maria Andruschenko, LPC-MHSP, to charge the indicated credit card for fees associated with therapy services provided, including, if necessary, adjustments for any changes to my account or fees associated with cancellation of scheduled appointments with less than 24 hour notice or excessive emergencies. I agree that charges will be applied to my credit card according to my utilization of services.

DIAGNOSTIC ASSESSMENT / IN-TAKE EVALUATION

Client Name: **DOB:** **Intake Date:**

I understand that Maria Andruschenko, LPC-MHSP, will not mail me any invoices or bills. I agree that if I have any problems or questions regarding my account or any services provided by Maria Andruschenko, LPC-MHSP, I will contact Maria Andruschenko for assistance at (615) 830-3178. I also agree that I will not dispute any charges with my credit card company without first making a good faith effort to remedy the situation directly with Maria Andruschenko, LPC-MHSP.

I guarantee and warrant that I am the legal card holder for this credit card and that I am legally authorized to enter into this recurring credit card billing agreement with Maria Andruschenko, LPC-MHSP.

Cardholder Name: _____

Card Number: _____

Exp. Date: _____ CVV Code: _____ Billing Zip: _____

By signing below, I accept, understand and agree to abide by the contents and terms of this agreement and have had an opportunity to ask any questions I might have about payment policies and procedure.

_____ _____
Client Signature Date

_____
Client Name (Printed)

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED ON PAGES 1-14 ARE TRUE AND CORRECT:

CLIENT: _____ **DATE:** _____