HEART-TO-HEART

Depth Psychotherapy, Wellness & Recovery Services

OFFERING TRADITIONAL & NON-TRADITIONAL PSYCHOTHERAPEUTIC SERVICES, TECHNIQUES AND OPTIONS

TOOLS FOR LIVING A BALANCED & MEANINGFUL LIFE

SUSAN NEVADA BARNES NEBEKER, MA, LMFTA, CDPT | Depth Psychotherapist, Marriage & Family Therapist, Addiction Professional
WA State Chemical Dependency Professional Trainee #CO 60434793 | WA State Marriage and Family Therapy Associate #MG 60357819
P (509) 961-1671 F (509) 961-1672 C (509) 307-0665 | www.hearttoheartdepth.com | susan@hearttoheartdepth.com
6 South 2nd Street, Ste. #710 at The Larson Bldg., Yakima, WA 98901

Confidential Client Information and Agreement
(Intake Form)

Client Name _____ Today's Date_____

Partner/Name: _____How Long Together? _____

Children's Name(s) age(s) _____

If Client is a Minor, Name of Responsible Adult: _____

Address, City, State, Zip _____

Home Phone _____ Work Phone: _____Cell Phone: _____

Private email address: _____ Student? If yes, where and major? _____

May I leave messages for you at home? Yes/No May we leave messages for you at work Yes/No

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

Others Living in Home (name, age, relationship to client): _____

_____

Highest Level of Education: _____ Occupation _____

Client's Employer (optional) _____ How Long? _____

Name of Emergency Contact _____ Relationship _____ Phone _____

Address, City, State, Zip _____

Referred by/How did you hear about our services? _____

May we acknowledge our meeting to any referral source? _____

Have you received previous counseling and/or substance abuse treatment? YES _____ NO _____

If Yes, Name & number of therapist/Agency: _____

Past Diagnoses? _____ Months /Years in treatment? _____

Drink Alcohol? Y/N How Much? _____ How Often? _____

Use Other Drugs? Y / N What Kind? _____ How Often? _____

Name & number of primary care physician or health practitioner: _____

Name & number of psychiatrist or psychiatrist nurse practitioner: _____

Any current medical or mental health conditions being treated?

Any current medications? Yes___ No ___ (If yes, please list & include daily dose amounts) _____

_____

Have you Ever Been Hospitalized for a Mental Issue? _____ When & What For _____

Any Previous Therapy/Counseling? ____ If Yes, When, Name, and location of Therapists _____

_____

Check Any of the Following That May Currently Apply to Your Life:

☐Headaches	☐Feel Unworthy or	☐Unlovable Shy With People
☐Dizziness	☐Feel Tense	☐Difficulty With Family & Friends
☐No Appetite	☐Feel Panicky	☐Unable To Have A Good Time
☐Over-Eating/Under Eating	☐Have Fears or Phobias	☐Always Worried About Something
☐Stomach Trouble	☐Obsessions	☐Lower or Higher Energy Than Usual
☐Always Tired	☐Depressed	☐Difficulty Making Decisions
☐Unable To Relax	☐Suicidal Ideas	☐Difficulty Concentrating
☐Insomnia	☐Anxiety	☐Financial Problems
☐Nightmares	☐Feel Despair	☐Addictions
☐Hallucinations	☐Sexual Problems	☐Job Problems
☐Recent Loss	☐Feel Lost	☐School Problems
☐Relationship Problems		

Other_____

Do we have your permission to discuss or receive treatment records and /or to receive diagnostic records from your past or current therapist, psychiatrist, and/or to disclose or share our clinical information with your past or current therapist, psychiatrist, and/or physician? YES ____ NO ____

Signature [required] _____ **Date**: [required] _____

Personal & Family Information

Ethnic identity & background _____Current relationship status _____

My birth parents currently: Married/live together _____ Separated _____

Divorced _____Never lived together _____Deceased _____

Other _____

Family of Origin [parents/step parents, adoptive parents, siblings]

Name (optional)	**Relationship to you**	**Age or deceased**

Current Family & Household [partner/spouse, roommates, children]

Name (optional)	**Relationship to you**	**Age/deceased**

Please name family of origin (significant caretakers and siblings that you grew up with or the first social group you belonged to, which is usually your biological family or adoptive family) and current family (basic social unit consisting of parents and their children, considered as a group, whether dwelling together or not).

Name or check all that apply

History of:	**Family of Origin**	**Current Family/ Household**
Counseling	_____	_____
Alcohol dependence	_____	_____
Drug dependence	_____	_____
Chronic physical illness	_____	_____
Chronic mental illness	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Eating Disorders	_____	_____
Domestic Violence	_____	_____
Sexual abuse and/or incest	_____	_____
Psychiatric hospitalization	_____	_____
Suicide Attempts	_____	_____
Death/Loss	_____	_____

Any more you would like to add:

_____

_____

Check all that apply:

I use alcohol: never _____ less than once per week _____ more than once per week _____ daily _____

I use drugs: never _____ less than once per week _____ more than once per week _____ daily _____

I use tobacco: never _____ less than once per week _____ more than once per week _____ daily _____

I have experienced an unwanted sexual experience: recently _____ in the past _____ sexual assault _____ date rape _____ incest _____

My sleep is: _____ hours a night / Frequent waking? _____(y/n) / Difficulty falling asleep? _____ (y/n)

Staying asleep? _____ (y/n)

I am dissatisfied with my personal appearance _____ (y/n)

I have felt like or tried to hurt myself in the past _____ (y/n) I am currently hurting myself _____ (y/n)

I have suffered a recent significant loss or death? _____ (y/n)

Explain: _____

I have suffered a recent relationship ending? _____ (y/n)

Explain: _____

I have experienced:

_____ (y/n) medical complications at birth

_____ (y/n) serious head injury (or knocked out)

_____ (y/n) past learning disability or attention deficit/hyperactivity disorder

_____ (y/n) permanent disability (if checked yes, please describe _____

_____ (y/n) legal difficulties (if checked yes, please describe) _____

Please state briefly your reasons for seeking mental health services at this time.

_____
_____
_____
_____
_____
_____
_____
_____

What are your current goals that you wish to achieve while participating in counseling?

_____
_____
_____
_____
_____
_____

How do you currently believe you can best achieve those goals?

_____
_____
_____
_____

How would you like things to be different after you have participated in counseling/consultations?

_____
_____
_____

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?

_____
_____
_____
_____
_____

Anything else you would like to add:

_____
_____
_____
_____
_____
_____
_____
_____

FEES & METHOD OF PAYMENT: Cash or check due at the beginning of the appointment.

FREQUENCY OF SESSIONS: Sessions are normally 50 minutes, once a week. It is sometimes in the client's best interest to meet more frequently. This is assessed on a case by case basis. Also, there may be a need (such as in couple's counseling, family therapy or group therapy) to meet for extended sessions. These typically might be 90 - 100 minutes. The fee will be adjusted accordingly. These decisions are made collaboratively with clients.

CANCELLATION POLICY: There is a 24 hour cancellation policy. Except in a true medical emergency or natural disaster, the client is responsible for the fee if session is canceled with less than 24 hour notice, or if client doesn't attend scheduled appointments. Insurance companies do not pay for these.

TREATMENT BY REGISTERED ASSOCIATE: I consent to receiving counseling from a Licensed Marriage & Family Therapy Associate supervised by Cynthia C. Ridgway, LMHC #00011271.

AFTER HOURS AND EMERGENCY ACCESS POLICY: If you have a life threatening emergency call 911 or go to your closest emergency room. In all other situations, leave a message and I will return your call within 24 hours. The only exception to this policy is if you have been notified that I will be unavailable.

PATIENT RIGHTS:

☐The right to be treated with dignity and respect child

☐The right of confidentiality, except in situations where there may be or elder abuse, you may be a danger to yourself or others or court ordered requests for information (see HIPAA attachment).

☐The right to participate in treatment decisions

☐The right to voice a complaint or appeal a decision about your care

ACKNOWLEDGEMENT OF THE ABOVE, RECEIPT OF NOTICE OF MENTAL HEALTH PRIVACY PRACTICES- HIPAA, AND ACCURACY OF INFORMATION GIVEN:

SIGNED: _____ DATE: _____