ADULT INTAKE PACKET

Name: _____ Date: _____

Referred by: _____

Home: _____

Cell:_____

Address: _____ City: _____

Zip: _____

Age: _____ Birthdate: _____

Email:_____

Please list how long, to all that applies below:

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

Ethnicity: _____ Religion: _____

Name of 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?
_____

_____

_____

_____

ADULT INTAKE PACKET (fill out in advance)

Do You Have Any Serious or Chronic Medical Conditions?_____

_____

If Yes, Dates & Details:_____

_____

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?

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?_____

ADULT INTAKE PACKET
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)

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 (MIX A/D)**

_____ **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)**

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)

MODIFIED HCL-32 QUESTIONNAIRE

Please try to remember a period when you were in a "high" or energized state. How did you feel then? Please check these statements even if you do not feel that way currently. Please put a check mark by each that have applied in the past or now.

	Description	
1	I need less sleep	
2	I feel more energetic and more active	
3	I am more self-confident	
4	I enjoy my work more	
5	I am more sociable (make more phone calls, go out more)	
6	I want to travel and/or do travel more	
7	I tend to drive faster or take more risks when driving	
8	I spend more money/too much money	
9	I take more risks in my daily life (in my work and/or other activities)	
10	I am physically more active (sport etc.)	
11	I plan more activities or projects.	
12	I have more ideas, I am more creative	
13	I am less shy or inhibited	
14	I wear more colorful and more extravagant clothes/make-up	
15	I want to meet or actually do meet more people	
16	I am more interested in sex, and/or have increased sexual desire	
17	I am more flirtatious and/or am more sexually active	
18	I talk more	
19	I think faster	
20	I make more jokes or puns when I am talking	
21	I am more easily distracted	
22	I engage in lots of new things	

23	My thoughts jump from topic to topic	
24	I do things more quickly and/or more easily	
25	I am more impatient and/or get irritable more easily	
26	I can be exhausting or irritating for others	
27	I get into more quarrels	
28	My mood is higher, more optimistic	
29	I drink more coffee	
30	I smoke more cigarettes	
31	I drink more alcohol	
32	I take more drugs (sedatives, anti-anxiety pills, stimulants	

ADULT INTAKE PACKET
CREDIT CARD AGREEMENT

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the therapist at your initial session. Sessions are $200 for 50 minutes or $275 for 80 minutes. 80 minute sessions are recommended for trauma work.

CC Type: MC Visa Amex Other _____

Name as shown on card _____

CC Number _____

3-digit security code on back of the card _____

Billing zip code associated with the card _____

Expiration Date _____

This card may be charged for:

Regular session fees (at your request, as a convenience to you) Check, Cash, Venmo, Zelle also available

Fees for cancellation without 24 hours' notice (according to Policy)

Delinquent session fees (fees more than 30 days overdue)

Agreement:

"I _____ (print name) have read and understand the terms of providing my credit card to Jennifer Brady, LCSW. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

_____ (Signature) _____ (Date)

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 us immediately.

We 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 therapy process, we are bound by ethical responsibilities to keep confidential the information shared during the sessions and we will not release any information without your written permission. There are important **exceptions to the confidentiality** of the therapy relationship. We are 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 50 or 80 minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority 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, venmo, zelle, check or cash. All checks and credit cards will be paid to Jennifer Brady, LCSW. 50 minutes sessions are $200, and 80 minute sessions are $275.

CHECKS/OVERDUE ACCOUNTS:
There is a fifteen-dollar ($15.00) service charge for all checks returned by the bank.

TELEPHONE, TEXT AND EMAIL POLICY:
Generally, we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us 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, we 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 our regular rates (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE:
We are what is referred to as an "Out of Network Provider." We do not bill your insurance company and payment is due at each session. However, we will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

PHYSICAL EXAMINATION:
We 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.

TRAINING AND SUPERVISION:
We may provide your therapy by pre-licensed therapists. Your case may be discussed in a group or individual supervision format with a licensed supervisor present for feedback, education, and discussion.

EMERGENCIES:
Therapy services are available only during scheduled office hours. In a crisis, you may utilize the Los Angeles County Mental Health Crisis Service (phone: 800-854-7771)

If you have any questions about our policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read our 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: _____