

McLean Counseling

150 South East 80th Ave
Portland, Oregon 97215
(503)780-7346

Christie McLean, MSW

INTAKE INFORMATION

| | | |
|---|---------------|-------|
| Name: _____ Telephone: _____ | | |
| Alternate Phone: _____ Date of Birth: _____ | | |
| Address: _____ Age: _____ | | |
| Marital Status: _____ Religion (opt.): _____ | | |
| Type of Employment: _____ | | |
| Name of Additional Person(s) to be involved in counseling: | Relationship: | Age: |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| <input type="checkbox"/> It is okay to leave a message on my phone. If not, message number: _____ | | |
| How shall we identify ourselves? _____ | | |
| <input type="checkbox"/> You may send mail to the above address. | | |
| <input type="checkbox"/> Please send mail to this address: _____ | | |

GENERAL INFORMATION

Please briefly explain why you are seeking counseling at this time?

On the scale below, please indicate how upsetting your problem(s) is/are right now:

- Mildly Upsetting Moderately Upsetting Very Upsetting
 Extremely Upsetting Totally Upsetting

When did your problem(s) begin? _____

Please describe any important events occurring at that time, or since then which may have started the problem(s) or which keep them going:

What solutions to your problem(s) have you found helpful? _____

What do you expect from therapy? _____

How many sessions do you think it will take to resolve the problem(s) that brought you counseling?

1-3 4-6 7-10 10-15 16-20 over 20

Therapy will not resolve the problem(s)

If seeking individual counseling and the need arises, would other relative(s) be willing to come to therapy? Yes No

If no, please indicate the reason: _____

REFERRAL INFORMATION

Please explain how you heard about our office and how you were referred:

Friends Agency Pastor/Clergy Relatives Court System Other: _____

Reason for referral: _____

Have you (or anyone attending) ever been involved in therapy or any other type of counseling programs? Yes No

If yes, When? _____ Where? _____

Reasons: _____

How would you describe your reaction to counseling?

Satisfied Somewhat Satisfied Not Satisfied

Are you in treatment with another counselor at this time? Yes No

If yes, with whom? _____ How long? _____

PERSONAL HISTORY

Have you ever been hospitalized for any mental health reasons? Yes No

If Yes, When? _____ Where? _____

By whom? _____ How long? _____

How much do you smoke? _____

How much do you drink and how often? _____

Do you think you, or anyone you live with, drinks too much? Yes No

Do you, or anyone you live with, use street drugs? Yes No How often? _____

If yes, please indicate what you are using: _____

Has you or anyone you live with, ever been treated for any type of chemical dependency abuse? Yes No If yes, when? _____

Where? _____ Length of treatment? _____

Is there a history and/ or family pattern of:

Physical Abuse Sexual Abuse Substance Abuse

Pornography Use Marital Affairs

Please explain: _____

Please indicate any of the following behaviors that apply to you or those seeking counseling (use initials to differentiate persons):

- High Blood Pressure
- Alcohol Problems
- Unusual Physical Symptoms
- Overeating
- Smoking
- Vomiting
- Phobic Avoidance
- Outbursts of Temper
- Lazy
- Loss of Control
- Spiritual Concerns
- Work Too Hard
- Compulsion
- Marital Affairs
- Sleep Disturbances
- Take Too Many Risks
- Impulsive Reactions
- Depression
- Epilepsy
- Drug Problems
- Strange or Unusual Sensations
- Odd Behavior
- Crying
- Legal Problems
- Nervous Tic
- Insomnia
- Aggressive Behavior
- Procrastination
- Drink Too Much
- Suicidal Attempts
- Concentration Difficulties
- Withdrawal
- Can't Keep A Job
- Eating Problems
- Pornography Use

Are you presently under a physician's care for physical problems? Yes No

Please list any prescription medication you are currently taking: _____

Name of physician? _____ Phone: _____

Have you ever been arrested and/or committed a crime? Yes No

If yes, please indicate when _____ For what: _____

Outcome of situation: _____

Are you or anyone you live with experiencing domestic violence/ feel unsafe?

Yes No

Has your Bishop, Priest, or Clergy made a special effort to talk to you about your behavior or the behavior of a member of your family? Yes No

Have the police or other social agencies interfered in your family? Yes No

Has there been any other outside disturbances to your family? Yes No

Is there anything else you feel is important for us to know or understand about you, your family, or about the reason you are seeking counseling at this time? Please explain:

Person to contact in case of an emergency: _____
Telephone: _____ Relationship to you: _____

Signature

Date

Signature

Date

Signature of Therapist

Date

Confidentiality Policy

TO ALL CLIENTS:

If at any time you believe a concern arises in your treatment, please discuss it with your therapist.

Please read the following information about the confidentiality policy and ask for clarification if necessary.

Every effort is made to ensure your complete privilege of confidentiality. Your treatment and all information pertaining to it will not be shared without your permission. You and your therapist may decide that gathering information from a third party will facilitate your current treatment. In that case you will be asked to sign a CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION form indicating the third party you give this therapist permission to contact. This Release of Information can be revoked at any time.

The following are a list of circumstances in which your privacy will be waived:

1. Reporting suspected child abuse, elder abuse or abuse of handicapped persons;
2. Reporting imminent danger to client or others;
3. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
4. Providing information concerning licensee case consultation or supervision; and
5. Defending claims brought by client against licensee;

In most cases, you will be informed that your confidentiality will be waived for one of the above reasons. In cases where there is a serious concern about increased risk, you may not be informed of the need to break confidentiality.

I have read and understand the above confidentiality policy.

Signature

Date

Signature

Date

Signature of Therapist

Date