Christie A. McLean, MSW

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(503) 780-7346

INTAKE INFORMATION

Name:_____ Sex: M / F Date:_____

DOB:_____ Age:_____ Email: _____

Address:_____
Street City Zip State

Phone: Home _____ Cell _____

May we call you at home? Yes___ No ___ May we call your cell phone? Yes___ No___

Referred by _____

BRIEFLY EXPLAIN WHY YOU ARE SEEKING COUNSELING

_____

_____

_____

_____

FAMILY INFORMATION

Spouse/Partner ____Status: __Married __ Separated __Divorced __Single ___Widowed

Spouse's or partner's name (if applicable) _____

History of mental illness *(ex. Depression, Anxiety, manic-depressive, suicide attempts, , ADHD, etc*

_____ Family member _____

Prior hospitalization for mental health illness Yes _____ No _____

Where _____ When _____

MEDICAL HISTORY

Physician_____ Phone #_____

Current health Problems_____

Medications *(include dosage and frequency)* _____

TRAUMA/COUNSELING HISTORY

Have you been verbally abused or verbally abused someone else? __Yes __No
Have you been physically abused or physically abused someone else? __Yes __No
Have you been sexually abused or sexually abused someone else? __Yes __No
Other stressors or traumas?

Have you seen to a counselor before? ___ Yes ___No

Counselor _____ Phone #_____

PLEASE CHECK THE BEHAVIORS AND SYMPTIONS THAT OCCUR TO YOU MORE OFTEN THAN YOU WOULD LIKE

Aggression/fighting	Elevated Mood	Panic attacks	Other:
Alcohol Abuse	Fatigue	Phobias/fears	
Angry outbursts	Gambling	Recurring thoughts	
Arguments/conflicts	Hallucinations	Sexual addiction	
Anxiety	Hopelessness	Sexual difficulties	
Avoiding People	Impulsivity	Sleeping problems	
Cutting	Irritability	Speech Problems	
Depression	Judgment errors	Suicidal attempts/ideation	
Domestic Violence	Loneliness	Trembling	
Drug Abuse	Memory Impairment	Withdrawing	
Eating Disorders	Mood swings	Worrying	

Briefly describe how the above-circled symptoms impair your ability to function effectively _____
_____

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else: ___Yes ___No
If Yes please describe the situation: _____
_____
_____

Have you ever purposely hurt yourself or someone else? ___Yes ___No. If Yes please describe the situation:
_____
_____
_____

Is there anything happening NOW in your current living situation or in your family that is especially stressful to you?
_____
_____
_____

Do you feel safe in your current living situation? ___Yes ___No

SUBSTANCE USE

SUBSTANCE USE (if present or past substance abuse, please indicate frequency)					
	None	Present	Frequency	Past	Frequency
Alcohol	☐	☐		☐	
Non-Prescription Drugs	☐	☐		☐	
Prescription Drugs	☐	☐		☐	
Marijuana	☐	☐		☐	
Cocaine/crack	☐	☐		☐	
Heroin/opiates	☐	☐		☐	
Meth Amphetamines	☐	☐		☐	
PCP/LSD	☐	☐		☐	
Inhalants	☐	☐		☐	
Other:	☐	☐		☐	
Have any substances created a problem for you at home, work or school? ☐ No ☐ Yes ☐ Not applicable					
If Yes, indicate type of problems:					
Have you ever been treated of hospitalized for substance use:					

FEES AND SCHEDULING APPOINTMENTS

My normal fees for a 50 minute session are $70. However, I provide a generous sliding fee scale for those for whom it would be helpful. Please ask regarding the discount fee if it is needed. To schedule an appointment, please either phone or email me. If you need to cancel an appointment, please do so 24 hours prior to your appointment. If you do not do so, you are responsible for the cost of your appointment. To avoid this charge you may reschedule an appointment within the same week if there is one available. This makes my availability open for other clients who would like that date and time. Thank you very much for showing this consideration to all my clients.

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 is 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 other relevant agencies;
4. Providing information concerning licensee case consultation or supervision;
5. Defending claims brought by client against this clinician.

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**

Person to contact in case of an emergency _____

Phone # _____ Relationship to you _____

I affirm that the above information is true to the best of my knowledge and request Christie McLean to provide counseling services for me.

_____ _____

Signature **Date**