Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____
_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

11. What significant life changes or stressful events have you experienced recently? _____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____
_____

3. What do you consider to be some of your strengths? _____
_____
_____
_____

4. What do you consider to be some of your weaknesses? _____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy? _____
_____
_____

Consent for Therapeutic Services

Information about the therapist:

My name is Katrina Ramos and I am a Licensed Marriage and Family Therapist. I have been licensed since 2012 and practicing as a therapist since 2005. I specialize in trauma treatment and treatment of anxiety in both children and adults. My passion for the brain and how it stores trauma and reacts to anxiety has led me to utilize resources from many treatment modalities including Eye Movement Desensitization Reprocessing (EMDR). I have been training in EMDR and use this and other modalities as they relate to achieving the patient's goals for treatment.

Information about this Practice:

This practice name is Katrina Ramos and is owned and operated by one owner.

Katrina Ramos	LMFT	51683
Therapist name	License type	License number

Fees and Insurance:

The fee for service is $____125_____ per session via 55 min session.
Individual and conjoint sessions are 55 minutes in length.
Longer sessions are at times recommended when doing processing and are charged as follows:
80 minutes $ 185
110 minutes $ 250

Fees are payable at the time of services are rendered. Please ask if you wish to discuss a written agreement that specifies an alternative agreement.

At this time health insurance is not accepted at this practice, however if you wish to bill your own insurance a super bill can be supplied for you in 5 business days of the request for a super bill.

No-secrets Policy

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples' therapy. This means that if you participate in family, and/or marital/couples' therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

sign here

_____

Signature of person authorizing consent of services Date

Client Rights:

Clients are also assured of confidentiality, which is a protected ethical right and a California state law, subject to legal limits. Cases may be discussed with other therapists within this agency in order to provide continuing care and/or treatment options. Should we believe it beneficial to us and to you to consult with another professional outside our agency regarding your case, we shall notify you and obtain a release of information signed by you. At times, we may seek professional supervision or consultation of the case without identification of the client in any way. There are some exceptions to confidentiality, which are addressed below.

Duty to Warn-Confidentiality

The following are exceptions to confidentiality:

- We are required by law to report any incidence of suspected child abuse, neglect, or molestation in order to protect the child involved;
- In legal cases, we or our records may be subpoenaed by the court system;
- Whenever obligated by law or a judge to share confidential information;
- Whenever there is a legal exception to confidentiality; You authorize us to notify relevant other (including a possible victim) and/or law enforcement authorities
- if we judge that a client has an intention to harm self or others.

Other Exceptions to Confidentiality are as follows:

- Insurance verification
- In divorce cases in which parents share joint custody, either parent has a right to the child's record, unless otherwise stipulated in the divorce decrees.

I agree with the following:

- I have read, understand, and agree to the Confidentiality Statement and the
- Informed Consent/Duty to Warn (exceptions to confidentiality) for treatment with Katrina Ramos I am aware of its content and policies and understand that a copy of this Signature Statement will be a part of my case record.

- I have read it and if necessary, I have discussed and clarified my understanding of it with Katrina Ramos.
- I agree to abide by the terms/policies set forth in this document.

- I consent to have the above-named minor(s) receive therapeutic services provided through Katrina Ramos without a parent or guardian present.

Signature of person authorizing consent of services Date

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

TeleCounseling

TeleCounseling is a means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

If you desire to use telehealth,all laws regarding the confidentiality of health care information and a patient's right to his or her medical information shall apply to telehealth interactions.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____CVV _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date