



"Life is comprised of continuous opportunities to practice."

3650 Auburn Blvd. #C-208, Sacramento, CA 95821 / 3050 Fite Circle #205, Sacramento, CA 95827
5651 N. Pershing Ave. #B-5, Stockton, CA 95207 / 510 49th Street #202, Oakland, CA 94609
Main Line: (916) 300-6576

CLIENT INTAKE FORM

Confidentiality: What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to child abuse, elder abuse, threatened homicide or suicide, or threatened or real fatal harm to self or harm to others.

 For couples/family therapy your counselor may utilize a "No Secrets" Policy. This means that if
Initials you participate in family/marital/couples therapy, your counselor is permitted to use information obtained in an individual session with other members of the family unless you specifically tell your counselor not to disclose certain information. I AGREE or I DO NOT AGREE to a "No Secrets" Policy.

Email/Text Disclosure: If you choose to correspond with us using email or text, please be advised that although we take responsible precautions to ensure confidentiality through email or text, we cannot guarantee secure electronic transmissions arising from the use of email or text or any attachments.

Counselors: Counseling is provided either by Licensed Therapists or by counselors who are in training to become Licensed Marriage & Family Therapists (MFT) or Licensed Clinical Social Workers (LCSW) and are in a weekly group supervision to discuss cases with a qualified licensed therapist.

Fees and Payments: Your fee is based on a sliding fee scale according to your household income. We request you pay your fee at the time of each session. You are responsible for any bank fees incurred due to returned or re-deposited checks. If you prepay, credits will be applied or we can offer a tax-deductible receipt for overpayments as a donation, there are no refunds given.

Cancellations: Cancellations need to be made 24-hours in advance. If an appointment is cancelled or missed without a 24-hour notice, you may be charged for the fee.

Your Session: The therapy session is 50 minutes in duration.

Counseling Process: Counseling is a partnership between you and your counselor and progress depends on many factors that include motivation, effort, and a willingness to participate and cooperate. You have a right to agree or disagree with your counselor and ask questions about the process. During counseling there may be times that you remember unpleasant or disturbing events from your past and can bring about some intense emotions. The benefits of counseling can include the ability to better cope with your relationships, increase in your self-awareness, personal growth, and you may achieve your personal goals. Counseling can bring resolution of the presenting problem or can bring unwanted and unexpected changes. Our counselors bring expertise and knowledge to help you make healthy and appropriate decisions and choices for yourself.

We hope your experience at Life Practice Counseling Group is a positive one and assists you in the development of your life. Signing says you agree to and fully understand the contents of this intake.

Client's Signature _____ Date _____

Counselor's Signature _____ Date _____ 4/16/11



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NEW CLIENT INFORMATION

Welcome. So that we may assist you, please complete the following:

Date: _____ Marital Status: _____ Occupation: _____

Name: _____ Date of Birth: _____ Age: _____

Name of Significant Other: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____

Home phone: () _____ Cell phone: () _____

Work phone: () _____ Fax: () _____

If we call, can we identify ourselves as counselors from Life Practice Counseling? Yes__ No__

Can we contact you by email? Yes__ No__ Email Address: _____

Emergency contact: _____ Phone: _____

Emergency contact: _____ Phone: _____

Highest Grade Completed in School: _____ Monthly Income: _____ (Couples combine)

Physician: _____ Phone: _____ Last Checkup Date: _____

Medications currently taking: _____

Reason for Counseling: _____

Previous psychotherapy? Yes __No __Year and reason: _____

On average how many days/week do you drink alcohol? _____ **How many drinks/day?** _____

Have you ever tried drugs? __ **What types?** _____ **Currently using?** __ **How often?** _____

How did you find us? Yahoo Google Yellowpages.com Craigslist Facebook Other: _____

May we know who referred you? _____

Termination of Therapy: You have the right to terminate therapy at any time and as you reach the end of your goals, you and your counselor will discuss termination. Therapy can be terminated if either of you feel you are not benefiting from therapy, if the counselor can no longer be objective, if you have not paid for the last two sessions, or failed to provide a 24-hr notice of cancellation two or more times. Treatment alternatives will be provided.

Your signature: _____ Date: _____



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HIPAA Notice of Privacy Practices

1. This notice describes how medical information about you may be used and disclosed electronically and how you can get access to this information. Please review it carefully.
2. I have a legal duty to safeguard your protected health information (PHI) when I transmit information electronically.

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website.

WHAT THIS MEANS: This only applies to you if you agree that I can contact you via email or other electronic means, as we cannot guarantee confidentiality through those means. We are bound by law and ethical standards to maintain your confidentiality. Since we cannot guarantee confidentiality through email, HIPAA laws take effect and you control how your private information gets transmitted to you. At Life Practice Counseling we will email schedule times and appointment confirmations only if you give your consent to do so.

Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Life Practice Counseling Group.

Signature: _____ Date: _____

Please check the feelings that apply to you today:

AI

- 1. I feel tense most of the time.
- 2. I have a lot of physical problems that can't be explained.
- 3. I worry most of the time.
- 4. I have compulsions such as constant hand washing, checking the door locks repeatedly, or other rituals that interfere with my daily activities.
- 5. I have nightmares and/or "flashbacks" that I can't get out of my head.
- 6. I have experienced sensations of shortness of breath, heart palpitations or shakiness while resting.
- 7. I avoid social situations because I am fearful.
- 8. There are some things I am really afraid of.
- 9. I am afraid to leave my house.
- 10. I think about dying or killing myself.
- 11. I have thoughts constantly in my mind which interfere with my ability to concentrate and function effectively.

DI

- 1. I no longer have any interest in the things that used to interest me.
- 2. I feel hopeless about the future.
- 3. I can't make decisions because I have a difficult time concentrating.
- 4. I feel sluggish or restless.
- 5. I am gaining or losing weight without trying to.
- 6. I get tired for no reason.
- 7. I am sleeping too much, or too little.
- 8. I feel unhappy.
- 9. I become irritable or anxious easily.
- 10. I think about dying or killing myself.
- 11. I have spontaneous urges to cry.



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