CLIENT INTAKE FORMS

Sara Roth, PhD, IMFT-S, LPC
CLEVELAND COUNSELING CENTER
23360 Chagrin Boulevard
Suite #102
Beachwood, OH 44122
dr.sara@clevelandcounselingcenter.com

Please fill out the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Birth Date: _____/_____/_____ Age:_____

Name:_____

Address (Street and Number):_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____

May I Leave a Message

- ☐ Yes
- ☐ No

Cell/Other Phone: (_____) _____-_____

May I Leave a Message

- ☐ Yes
- ☐ No

E-mail: _____

May I Email You?

- ☐ Yes
- ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:

Place of Employment:_____

Work Number: (_____) _____-_____

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (_____) _____-_____

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Referred by:

- ☐ Medical Provider: _____
- ☐ Theravive
- ☐ My Website
- ☐ PsychologyToday
- ☐ Google
- ☐ AAMFT Therapist Locator
- ☐ Therapy Den
- ☐ Marriage.com
- ☐ EMDRIA
- ☐ Friend/Family: _____
- ☐ Other: _____

Have you previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

Are you currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- ☐ Yes
- ☐ No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

_____

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

What would you like to accomplish out of your time in therapy

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced -- For how long?
- ☐ Widowed: Please provide your partners name and year deceased:

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Phone, email, or Fax: _____

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How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Awakening early
- ☐ Sleep apnea

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

Family History

Please identify if there is a family history of any mental health issues. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.)._____

_____

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PRACTICE POLICIES

- ☐ Sessions are 50 minutes. This includes the time allowed to schedule appointments and collect fees. Out of respect for each of my clients, I do my best to start and end sessions on time. I ask that you arrive on time for your appointment. Late arrivals will cut into some of your session time.

- ☐ Session fee is $150 per 50 minute session. Payment can be made by cash, check or credit card. Payment is due at each session. If you choose to pay by credit card, it may be more convenient to submit a card on file.

- ☐ Longer prorated sessions are also available. Please specify if you'd like to discuss the pros and cons and if that would make sense for you. If you are planning on using your out-of-network benefits, you may want to check with them first, as some insurance companies do not cover longer sessions.

- ☐ If your insurance plan includes out-of-network benefits, you will pay for your sessions at the time of service, and I can provide you the information you will need to submit to your insurance.

- ☐ If you need to change or cancel an appointment, please give 24-hour notice.

- ☐ In the event of a no-show or late cancel that is not an emergency or illness, the full session fee will be charged.

- ☐ According to my profession's ethical code, I am unable to interact socially on social media with clients, therefore I will not accepts requests to interact on social media.

- ☐ I am not always immediately available to respond in a crisis situation. In case of emergency, call 911, call the Crisis Hotline @ 216.623.6888, text the Crisis Text Hotline at 741-741 or go to the nearest emergency room.

Print Name:_____

Signature: _____Date:_____

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LIMITS OF CONFIDENTIALITY

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person.

Suicide/Self harm: Depression is a common emotion expressed in therapy.
If a client is feeling hopeless enough to imply or disclose a plan for suicide, steps need to be taken to ensure safety. This would include making reasonable attempts to notify the family and possible admission to psych emergency services.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.
Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above-stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Print Name:_____

Signature: _____Date:_____