CLIENT INTAKE FORMS

CLEVELAND COUNSELING CENTER
23360 Chagrin Boulevard
Suite #102
Beachwood, OH 44122
info@clevelandcounselingcenter.com
www.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**

Occupation:

Place of Employment:_____

Job Position: _____

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (_____) _____-_____

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Referred by:

- ☐ **Medical Provider:** _____
- ☐ **Theravive**
- ☐ **Therapy Tribe**
- ☐ **Good Therapy**
- ☐ **CCC Website**
- ☐ **PsychologyToday**
- ☐ **Google**
- ☐ **AAMFT Therapist Locator**
- ☐ **Therapy Den**
- ☐ **Marriage.com**
- ☐ **EMDRIA**
- ☐ **ICEEFT**
- ☐ **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:_____
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

Cleveland Counseling Center is Out-of-Network, or self-pay. Your credit card will be on file for payment. Payment is due in full on the day of each session. Session fees are $60 for a 50 minute session for trainee 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. Some insurance companies do honor out of network benefits when you are working with an intern. You can also utilize HSA and/or FSA credit cards.

Late arrivals will cut into some of your session time. 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.

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.

I understand that my therapist is a student intern, who is supervised by the practice owner, Dr. Sara E. Roth. I give my consent to
_____videotape and audiotape
_____audiotape only
our sessions, as I understand that it is beneficial for my therapist's supervision and advancement as a therapist.

Print Name:_____

Signature:
_____Date:_____

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INFORMED CONSENT

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.

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.
Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

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.

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: _____

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INFORMED CONSENT FOR TELETHERAPY SERVICES

- **There are potential benefits/risks of video sessions (e.g. limits to patient confidentiality) that differ from in-person sessions.**
- **Sessions will not be recorded by the therapist or client without permission.**
- **It is important to be in a quiet, private space that is free of distractions during the session. If you are using your cellphone, please quiet your notifications.**
- **It is important to use a secure internet connection rather than public/free Wi-Fi.**
- **It is important to be on time. If you need to cancel or change your appointment, you must notify me in advance by phone or email.**
- **We will need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.**
- **We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.**
- **Please consider checking if you are situated in a good spot before your session. For example, I will not be able to see you clearly if you are sitting in front of a bright light or sunlight. If this is a couples therapy session, please make sure you are both clearly visible.**

Name:_____
Signature:_____
Date: _____