Adriane Nada, MS, LMFT, LPCC
Integrative Psychotherapy
(949) 272-1692

Client Intake Form

Date:_____

Legal Name: _____ ☐ Male ☐ Female ☐ Other

Name you prefer: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____

Zip: _____ Email: _____

Home Phone: _____ ☐ Ok to leave message

Mobile Phone: _____ ☐ Ok to leave message

Preferred method of contact: ☐ Phone call ☐ Text message ☐ Email

Relationship Status: ☐ Single ☐ Married ☐ Cohabitating ☐ Separated

☐ Divorced ☐ Widowed ☐ Other: _____

Children (Names and ages):

_____

_____

Emergency Contact: _____ **Phone**: _____

Relationship: _____

Referred by (please check all that apply): ☐ Psychology Today ☐ Good Therapy

☐ Website ☐ Word of mouth: _____

☐ Other: _____

Adriane Nada, MS, LMFT, LPCC
Adriane@mind-bodycounseling.com

MFT CA License #45548
LPCC CA License #1090
MFT OR License #T1914
LPC OR License #C6506

Your answers to the following questions will provide additional information that will be beneficial to our counseling sessions. Please answer the questions below as completely as is comfortable for you.

Counseling

Briefly describe the problem that brings you to counseling: _____

_____

_____

_____

_____

How have you already tried to resolve this problem: _____

_____

_____

After counseling, what do you hope will be different regarding this problem? _____

_____

_____

What previous experience do you have with counseling? _____

_____

_____

_____

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Please mark any of the following symptoms you are experiencing:

- ☐ Aggression/Fights
- ☐ Anxiety/Worry
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Compulsive Behavior
- ☐ Excessive device use
- ☐ Crying Spells
- ☐ Depression/Sadness
- ☐ Distractibility
- ☐ Eating Problems
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Fear away from home
- ☐ Flashbacks
- ☐ Frequent Arguments
- ☐ Gambling Problems
- ☐ Guilt/Shame
- ☐ Hallucinations
- ☐ Hearing Voices
- ☐ Hoarding
- ☐ Homicidal
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Substance Use
- ☐ Impulsivity
- ☐ Irritability
- ☐ Lack motivation
- ☐ Libido Changes
- ☐ Loneliness
- ☐ Loss of Pleasure
- ☐ Low self-worth
- ☐ Nightmares
- ☐ Obsessive Thoughts
- ☐ Panic Attacks
- ☐ Parenting Problems
- ☐ Poor memory/Confusion
- ☐ Pornography Compulsions
- ☐ Racing Thoughts
- ☐ Relationship Problems
- ☐ Risky Activity
- ☐ Self-harm Behaviors
- ☐ Sexual Problems
- ☐ Shopping Problems
- ☐ Social discomfort
- ☐ Sleep Problems
- ☐ Suspicion/Paranoia
- ☐ Withdrawal from people
- ☐ Work/School Problems

Other: _____

Are you currently experiencing suicidal thoughts? ☐ No ☐ Yes
If yes, please describe:

_____

Have you ever experienced suicidal thoughts in the past? ☐ No ☐ Yes
If yes, please explain:

_____

Have you ever attempted suicide? ☐ No ☐ Yes If yes, when: _____
If yes, please describe the attempt:

_____

Are you or anyone in your household currently experiencing abuse or violence of any kind? ☐
No ☐ Yes

If yes, please explain: _____

_____

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Medical History

How would you describe your physical health? _____

_____

_____

Are you currently being treated for any medical conditions? ☐ Yes ☐ No
If yes, please explain:

_____

Are you currently taking medication for a mental health or medical condition?
☐ Yes ☐ No

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

What is your current or previous mental health diagnosis (if applicable)?

_____

Have you ever been treated for drug/alcohol use? ☐ No ☐ Yes If yes, when?

_____

Have you ever abused prescription drugs? ☐ No ☐ Yes If yes, which ones and when?

_____

Do you exercise regularly? ☐ No ☐ Yes If yes, explain what type(s) and how often:

_____

Describe your normal diet/eating habits: _____

_____

_____

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Family History

In a few words, describe what your relationship has been like with your:

Mother: _____

Father: _____

Siblings: _____

Other significant family members: _____

Before you were 18, did you experience any of the following?

- ☐ Parents Divorced (your age: _____)
- ☐ Adopted (your age: _____)
- ☐ Lived with step-parents/siblings
- ☐ Not raised by bio-parent

Have you experienced the death of someone close to you? ☐ No ☐ Yes
If so, please give name, relationship, and your age at the time:

_____

Did either of your parents' abuse drugs or alcohol? ☐ No ☐ Yes
If yes, please explain:

_____

Were the adults in your household abusive or disrespectful towards each other?
☐ No ☐ Yes
If yes, please explain: _____

Were you verbally, emotionally, sexually or physically abused? ☐ No ☐ Yes
If yes, please explain:

_____

Do any of your current or extended family members have a history of mental illness (depression, anxiety, attention deficit, bipolar disorder, etc.)? ☐ No ☐ Yes
If yes, please explain:

_____

_____

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What additional information about your childhood or family would be important to know?

_____

_____

Current Resources

Do you feel you have an adequate support system? ☐ No ☐ Yes

Please describe your network of social support (friends, co-workers, significant others, spiritual communities, self-help groups, etc.):

_____

_____

_____

_____

What are your interests, hobbies, activities?

_____

_____

_____

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Informed Consent

INTRODUCTION

This Client Consent Agreement (herein "Client Agreement" or "Agreement") is intended to provide [name of client] _____ (herein "Client") with important information regarding the practices, policies and procedures of Adriane Nada, MS, LMFT, LPCC (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

_____ (*Client Initials*)

THERAPIST BACKGROUND AND QUALIFICATIONS

Therapist is a Licensed Marriage and Family Therapist (LMFT) and a Licensed Professional Clinical Counselor (LPCC), independently working in private practice specializing in relationship counseling for couples and individuals. Therapist has a Master's degree in Counseling (with an emphasis on Marriage and Family Therapy) from California State University, Fullerton. Therapist uses research-based therapeutic interventions from Psychodynamic Theory, Eye Movement Desensitization and Reprocessing Therapy (EMDR), Humanistic/Existential Theory, and other mind-body approaches. Therapist's approach to therapy can be described as integrative and compassionate.

_____ (*Client Initials*)

RISKS AND BENEFITS OF THERAPY

Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Participating in therapy may result in a number of benefits to Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client. During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

_____ (*Client Initials*)

RECORDS AND RECORD KEEPING

Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any Client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

_____ (*Client Initials*)

CONFIDENTIALITY

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, or when a Client is dangerous to him/herself or the person or property of another.

_____ (*Client Initials*)

PHONE SESSIONS & VIDEO-CONFERENCING SESSIONS

In addition to in-person therapeutic services, Therapist also offers psychotherapy over the phone and by live video-conferencing through Zoom. Telehealth is defined as the delivery of psychotherapy services using information and communication technologies to consult, diagnose, treat, or educate Client while Client is at an "originating site" and Therapist is at a "distant site." Under Therapist is only permitted to provide Telehealth to Client while Client is in the state in which Therapist is licensed. The practice of Telehealth with Therapist involves providing psychotherapy through "synchronous interaction" which is real-time, interactive communication using the telephone or live video-conferencing. All practices, policies and procedures previously outlined in Client Consent Form Agreement are still in effect when Telehealth is added as a mode psychotherapy service delivery. Some of the main benefits of Telehealth include increased flexibility, portability, and access to psychotherapy for Client. Some of the risks of Telehealth include, but are not limited to, increased risk for breaches of confidentiality despite reasonable efforts on the part of Therapist due to disruption or distortion by technical failures or security breaches of technology as well as interruption by unauthorized persons. In order to minimize the risks as much as possible, Client is responsible for ensuring his/her privacy at the time of receiving Telehealth services (e.g. Client can ensure before the session that no third party is in the room or on another phone line overhearing the contents of the session.) If Therapist suspects that an unauthorized person is in listening distance of the Telehealth session, the session will be terminated and can be rescheduled for another time.

_____ (*Client Initials*)

THERAPIST AVAILABILITY

Therapist's office is equipped with a voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

_____ (*Client Initials*)

CLIENT LITIGATION

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $160 per hour. The information disclosed by Client, as well as any records created, is subject to the psychotherapist-patient privilege. Typically, the Client is the holder of the psychotherapist-patient-privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns regarding the psychotherapist-patient privilege with his/her attorney.

_____ (*Client Initials*)

FEE AND FEE ARRANGEMENTS

The agreed upon fee between Therapist and Client is **$160 per 55-minute session and $240 per 85-minute session**. If Client consists of more than one person (i.e. a couple or family), members of the unit of treatment (couple or family) are responsible for designating who will provide payment for session. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. From time-to-time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than fifteen minutes. Client is expected to pay for service at the time service is rendered. Therapist accepts cash, checks, major credit cards (including American Express, Visa, MasterCard and Discover).

_____ (*Client Initials*)

INSURANCE

Therapist is not a contracted provider with any insurance company, managed care organization. Should Client choose to use his/her insurance, Therapist will provide Client with a statement, which Client can submit to the third-party of his/her choice to seek reimbursement of fees already paid. Client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. If Client intends to use benefits of his/her health insurance policy, Client agrees to inform Therapist in advance.

_____ (*Client Initials*)

CANCELLATION POLICY

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least **24 hours**-notice of cancellation. Cancellation notice can be left on Therapist's voicemail at (949) 272-1692.

_____ (*Client Initials*)

TERMINATION OF THERAPY

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

_____ (*Client Initials*)

ACKNOWLEDGEMENT

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Client Name (please print)

_____ _____

Signature of Client (or authorized representative) **Date**

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