Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY
11900 SW Greenburg Road
Tigard, OR 97223
Phone: 503.620.5556
Fax: 503.624.0118

Adult Intake Form (for session with Scarlet Graham, LPC)
Please fill out this form and bring it to your first session.

Client's Name:_____ Today's Date:____/____/_____
Date of Birth:____/____/_____ Age: _____ Legal sex: ☐ Male ☐ Female
Partner's Name (if being seen as a couple):_____
Referred by:_____
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Other (specify): _____
Telephones: Home Phone: _____ Cell Phone: _____ Work Phone: _____
May I leave a message? ☐ Yes ☐ No
Others living in the home:

Name	Birthdate	Relationship to Client

Education: Client: _____ Partner: _____
Occupation: Client: _____ Partner: _____
Client's Employer: _____
Social Security Number: Client: _____ Partner (optional): _____
Emergency Contact: _____ Phone: _____

Presenting Problems
Describe the problems that brought you here today:
_____
_____
_____

Check any of the symptoms that you are experiencing:

- ☐ Depression
- ☐ Extreme sadness
- ☐ Feeling hopeless
- ☐ Feeling tearful
- ☐ Problems sleeping
- ☐ Memory problems
- ☐ Lack of energy
- ☐ Change in eating habits
- ☐ Weight changes
- ☐ Change in sexual interest or function
- ☐ Trouble concentrating
- ☐ Trouble performing your job
- ☐ Problems getting along with friends/family
- ☐ Lack of enjoyment in usual activities
- ☐ Self-esteem problems
- ☐ Easily irritated
- ☐ Perfectionism
- ☐ Feeling guilty
- ☐ Obsessions or compulsions
- ☐ Feeling nervous
- ☐ Sudden feelings of panic
- ☐ Moving or speaking so slowly that other people could have noticed
- ☐ Physical complaints of pain
- ☐ Muscle tension
- ☐ Problems with anger
- ☐ Acting violently
- ☐ Feeling tired or having little energy
- ☐ Thoughts of hurting yourself or others
- ☐ Feelings of extreme happiness
- ☐ Poor appetite or overeating
- ☐ Thoughts of killing yourself or others
- ☐ Feeling fearful

If you checked off any symptoms, how difficult have these symptoms made it for you at work, home, or with other people?
Please circle one: *Not difficult at all* *Somewhat difficult* *Very difficult* *Extremely difficult*

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Family History

	Name	Age	If living, city & state of residence If deceased, year of death
Father			
Mother			
Step-parent			
Step-parent			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Partner History

Name of Previous Spouse/Partner	Date of Marriage/ Living Together	Date of Divorce/ Separation

Children

Please list all of your children (both living and deceased).

Name	Birthdate or Age	Gender

Did your parents divorce or separate? ☐ Yes ☐ No If yes, how old were you? _____
With whom did you live with growing up? _____
Have you been physically abused? ☐ Yes ☐ No ☐ Don't remember
Have you been sexually abused? ☐ Yes ☐ No ☐ Don't remember
Did you witness abuse between parents? ☐ Yes ☐ No ☐ Don't remember
Did you witness abuse between parents & children? ☐ Yes ☐ No ☐ Don't remember
Have you ever considered or attempted suicide? ☐ Yes ☐ No If so, when? _____
Have other members or your family attempted or committed suicide? ☐ Yes ☐ No
If so, who & when? _____
Have you had any previous counseling experience or psychiatric hospitalization? ☐ Yes ☐ No
If so, when & with whom? _____
Was it helpful? ☐ Yes ☐ No Explain please: _____

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Medical Information

Have you seen a doctor or doctors within the past year? ☐ Yes ☐ No If yes, please fill out the table.

Doctor	Reason

What medicines (prescribed or over-the-counter), herbs, and vitamins do you take?

Medicine, Herb, Vitamin	Reason	Prescribing Doctor

Do you have allergies? ☐ Yes ☐ No If yes, describe allergy problems: _____

Do you use tobacco? ☐ Yes ☐ No If yes, what kind and how much daily?_____

Do you drink caffeine (coffee or tea)? ☐ Yes ☐ No If yes, how many cups a day? _____

How much alcohol do you drink? (average number of drinks per week) 0 1-5 6-10 11-20 over 20

What other drugs do you use? _____ How often? _____

Has your use of alcohol or other drugs caused problems or been a concern to you or others? ☐ Yes ☐ No

Have you sought treatment for problems with alcohol or other drugs? ☐ Yes ☐ No

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Scarlet Graham, MA, Clinical Mental Health Counseling
LPC -Licensed Professional Counselor

Professional Disclosure Statement

Philosophy and Approach to Counseling:
I believe that people hold the keys to a healthy emotional balance within themselves. By joining with the client in seeking emotional, physical, and spiritual health, an empowering environment develops. As I recognize and honor client strengths and resources, clients develop a means through which to address their issues and facilitate change. My goal as a counselor is to help clients identify personal needs, understand conflicts discover new options, and make informed choices. My approach to counseling is integrative with the utilization of a number of techniques to explore client concerns including; cognitive-behavioral philosophy (exploring one's thoughts and beliefs), that incorporates client-centered techniques (allowing the client to set the pace and topics of each session) and assist in developing coping skills and treatment goals together with you. My goal as a counselor is to help clients identify personal needs, understand conflicts, discover new options, and make informed choices.

Formal Education and Training:
I hold a Master of Arts degree in Clinical Mental Health Counseling from George Fox University and I and see children, adults and their families for comprehensive therapy. Major areas of course work include Psychopathology, Human and Child Development, Psychological theory, cognitive and behavioral therapy. One of my specialties, is working with adults and children on the high end of the Autism Spectrum-formerly called Asperger's. One of my passions is Sandplay Therapy, which is very effective for children and a recognized type of therapeutic modality for adults. In addition to my academic studies, I have additional training in Dialectical Behavioral, Emotion Focused, Intersubjectivity, Asperger's, Sandplay and Art Therapy, Early Childhood Development and Reactive Attachment Disorder in children.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

Fees: My fee is $150 for a 60 minute session.

Confidentiality and Client Bill of Rights:
As a client of an Oregon Licensee, you have the following rights:

A) To expect that a licensee has met the minimal qualification of training and experience required by the state law;
B) To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
C) To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);
D) To report complaints to the board;
E) To be informed of the cost of professional services before receiving the services;
F) To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions;
- Reporting suspected child abuse;
- Reporting imminent danger to client or others;
- Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
- Providing information concerning licensee case consultation or supervision; and
- Defending claims brought by client against licensee.

G) To be free from being the object of discrimination on the basis of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Information may also be disclosed if a client signs a written authorization.

Electronic transmission and caller identification-by phone, cell phone, email, FAX, or internet, increases risk for breach of confidentiality. It is okay to email or leave message on cell phone?

Please indicate: Yes _____ or No _____ Initial _____

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Professional Disclosure Statement (continued)

Voluntary Participation:
Therapy is understood to be a choice made by the client. Outcomes cannot be guaranteed; although it is our hope, it will be successful. Some clients need only a few sessions to achieve their goals, while others may require several months or years of counseling. Alternative options include other therapists, books, support groups, self-help resources, and other modes of treatment. Medical treatment may also be an option. A client has the right to terminate treatment at any time, however, it is understood that terminating prematurely may result in the return or worsening of symptoms.

Emergencies:
In the event of an emergency, you may contact the crisis line at Clackamas (503) 655-8585 or Washington County 503-291-9111, call 911, or report to the nearest emergency room facilities.
You may contact the Board of Licensed Professional Counselors and Therapists at
3218 Pringle Rd SE, #120, Salem, OR 97302-6312. Telephone: (503) 378-5499.
Email: lpct.board@state.or.us Website: www.oregon.gov/OBLPCT

Consent to Treatment:
Your signature below indicates consent to treatment under the conditions listed above.

_____
Client Signature (and/or Parent if under 14 years of age) Date

_____
Therapist's Signature Date

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Dear Patient,

In addition to the clinic policies outlined in SWFP's New Patient Paperwork, please review the points below regarding scheduling, appointments, and fees with me, Simone Crothers, LPC.

1. Rates are billed per your insurance coverage. If I have a binding contract with your insurance company, your co-pay serves as your responsibility for payment to our office. This payment is due at check-in prior to any visit. If I do not have a binding contract with your insurance company, I am considered an "Out of Network" provider. Based on your specific insurance plan, your fiscal responsibility for each visit may be more than that of an "In Network" provider. Please see the billing office for questions regarding rates per sessions and contact your insurance provider directly for all other inquiries.
2. All appointments (including all first evaluations), that are missed, cancelled, or rescheduled outside of the 24-hour window of the scheduled date and time are considered a "No Show", and will be billed at the full appointment rate of $150. Insurance will not cover your missed appointments, so it is important that you cancel/reschedule appointments at least 24-hours prior to your appointment to be considerate of others who may want to schedule in your place. Three or more "No Shows" per one 6-month period will result in a discharge from our behavioral health program.
3. If you are more than 10 minutes late to an appointment, please call the office and let Pam Bergeron, our behavioral health medical assistant, or any front desk staff member know that you are on your way, or you run the risk of not being able to be seen at your scheduled time and being charged a No-Show fee.
4. Most scheduling can be directed through Pam Bergeron, our behavioral health medical assistant, at 503.597.1215 or through the front desk if Pam is not available at 503.620.5556.
5. On a final note, if you have not been seen for an appointment in over 6 months, your file will be closed with me. A new initial assessment will be required to re-establish care.

Thank you for remembering these guidelines! If you have any questions, please ask and I will be happy to discuss them with you further.

Sincerely,

Simone Crothers LPC

I acknowledge that I have received and reviewed a copy of this document and am aware of its contents.

_____ _____ _____

Printed Name | Signature | Date

_____ _____

Patient's name if different than above | Relation to patient