Vienna Counseling

Date of First Appointment: _____/_____/_____

Client Contact Information:		
Full Name of Client:	Birth Date: / /	Age:
Street Address:		
City:	State:	Zip:
Parent or Guardian Name(s) - - if client is a minor:		
Check box if okay to leave messages		
Home Phone: ❑	Cell Phone: ❑	
Work Phone: ❑	Email: ❑	

Client Billing Information:
Billing Address (if different than above):

Emergency Contact:	
Name:	Phone:
Relationship to Client:	Alternative Phone:

Referred By:		
❑ Physician	❑ Psychiatrist	❑ Therapist
❑ Family	❑ Friend	❑ Website
❑ Other _____		

CONSENT TO TREATMENT & FINANCIAL AGREEMENT

I, _____ (name of client or guardian), agree and consent to the policies, procedures, fees, and payment arrangements as stated in the *Policies & Procedures* document provided. I understand that payment is collected at the time of service and that cancellations must be made 24 hours in advance to avoid a charge to my account. I understand that Vienna Counseling and its providers are not affiliated with any insurance companies and that it is my responsibility to seek out-of-network reimbursement should I choose to do so. I acknowledge and accept full responsibility for this account and guarantee payment of all charges against it. I have been given a copy of the *Notice of Privacy Practices (HIPPA)* document and agree and consent to the information provided.

Minor Consent: Please check this box if the client is under the age of eighteen or unable to consent to treatment and you are signing as the guardian. By doing so, you attest that you have legal custody of this individual and are authorized to initiate and consent for treatment on behalf of this individual. ❑

Your signature below indicates that you have read the information provided and understand and agree to abide by the terms and conditions.

_____ _____

Print Client Name Client Date of Birth

_____ _____

Signature of Client or Guardian Date Signed

CLIENT INTAKE INFORMATION

Legal Name: _____ Date: _____

Preferred Name: _____

Please answer the following questions, which will help me to obtain accurate background information that will be useful in our work together. Please skip any questions that you are not comfortable with or ready to answer, and feel free to discuss any concerns you have regarding this document in your next session. Information obtained in this document will be kept strictly confidential in compliance with HIPPA regulations.

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly describe the problem(s) and symptom(s) for which you are currently seeking help.

_____

_____

_____

_____

2. PROBLEM DURATION: Approximately how long have you had the current problem(s)? _____

3. PRECIPITATING EVENTS: Were there any precipitating events (e.g. major family illness or death, divorce, moving to a new residence, etc.)?

_____

_____

_____

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

_____

_____

_____

5. Have you had any difficulty falling or staying asleep recently? If so, briefly describe. **Yes / No**

6. Have you had any recent changes in eating or appetite, or problems with your eating habits? If so, briefly describe. **Yes / No**

7. Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

   ☐ Yes ☐ No

8. Have you had previous psychological counseling? ☐ Yes ☐ No

   If yes, to the best of your ability please note the your age and duration of previous counseling experience(s):

9. Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

   If yes, what hospital, approximate dates, precipitating event:

10. Are you currently taking prescribed psychiatric medication (antidepressants or others)? ☐ Yes ☐ No

    If yes, please list medication, dosage, and the approximate date treatment began:

Medication	*Dosage*	*Reason Prescribed*	*Approx Date Began*

11. If not currently prescribed medication, have you been prescribed such medications in the past?

☐ Yes ☐ No

If yes, please list medication, dosage, and the approximate date treatment began and ended:

Medication	*Dosage*	*Reason Prescribed*	*Approx Dates*

12. Are you currently taking any other prescribed medication (e.g., for hypertension, migraines, etc.)?

☐ Yes ☐ No

If yes, please list medication, dosage, and the approximate date treatment began:

Medication	*Dosage*	*Reason Prescribed*	*Approx Date Began*

13. Please list any current or on-going physical symptoms, chronic illnesses, or other health concerns or conditions (e.g. chronic pain, headaches, fibromyalgia, diabetes, etc.):

WORK & EDUCATIONAL HISTORY

1. List your current or most recent job/employment, along with your title/position. If student, please list school and current grade.

2. List the most recent education you have received (e.g., high school, vocational school, college).

HEALTH RELATED ISSUES

1. How many times per week do you exercise? _____ For about how long each time? _____

2. Do you regularly use alcohol? **Yes / No**

   How often do you use alcohol? _____

   What do you typically drink? _____

   Have you used more alcohol than you intended this year? **Yes / No**

   Have you ever felt the need to cut down on the amount of alcohol you drink? **Yes / No**

   Do you consider your alcohol consumption a problem? **Yes / No Unsure**

3. How often do you engage in recreational drug use?

   Daily Weekly Monthly Rarely Never

   Have you ever felt the need to cut down on the amount of drugs you use? **Yes / No**

   List any recreation drugs you currently use and how often you use them:

_____

_____

   Do you consider this drug use a problem? **Yes / No Unsure**

4. Is there a history or alcohol/substance abuse or dependence in your family? **Yes / No** (If yes, please specify)

_____

_____

5. Is there a history or mental health concerns or mental illness in your family? **Yes / No** (If yes, please specify)

_____

_____

6. Do you have any problems or worries about sexual functioning? **Yes / No** (If yes, circle applicable response):

   Lack of desire Performance Problem Sexual Impulsiveness Difficulties Maintaining Arousal

   Worried about STDs (Sexually Transmitted Diseases) Other _____

SOCIAL HISTORY AND OTHER ISSUES

1. Describe your relationship status: Single Domestic Partner Married Divorced Widowed

   Other (*specify*): _____

2. Gender identity & preferred pronouns: _____

3. Sexual orientation: _____

4. Describe your living situation (with whom, type of housing, etc.) below:

_____

_____

_____

5. List any family members that are currently a source of support for you:

_____

_____

6. List any friends that are currently a source of support for you:

_____

_____

7. List any other sources of support (i.e. Church, activities, etc.):

_____

_____

8. Have you ever experienced or witnessed domestic violence or abuse? **Yes / No**

9. Have you ever experienced sexual abuse, assault, or uncomfortable touching? **Yes / No**

10. Have you had suicidal thoughts recently? **Yes / No** (If yes, circle applicable response):

    Frequently Sometimes Rarely Never

11. Have you had suicidal thoughts in the past? **Yes / No** (If yes, circle applicable response)

    Frequently Sometimes Rarely Never

12. Have you ever attempted suicide? **Yes / No** (If yes, please list the age(s) of the attempt(s)) _____

13. Have you ever intentionally inflicted any other form of harm upon yourself? **Yes / No**

14. Have you intentionally inflicted any form of harm upon anyone else recently? **Yes / No**

15. Do you currently have any legal concerns or issues pending? **Yes / No** (If yes, please specify)

16. Please list any additional current stressors in your life:

Please list your goals for therapy:

Please note any additional information that you feel might be helpful for me to know: