Peacewise Counseling

Kathi Gerspach, MA PC

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150 South East 80th Ave
Portland, Oregon 97215

INTAKE INFORMATION

Name: ________________________________ Telephone: ___________________

Alternate Phone: ________________________ Date of Birth: __________________

Address: ____ Age: _____

Marital Status: ________________________________ Religion (opt.): __________

Type of Employment: ____

Monthly Household Income: ____________________ Fee FS: __________

Name of Additional Person(s) to be involved in counseling: Relationship: Age:

____ ___________ _____

____ ___________ _____

____ ___________ _____

____ ___________ _____

❑ It is okay to leave a message on my phone. If not, message number: _________________

How shall we identify ourselves? ____

❑ You may send mail to the above address.

❑ Please send mail to this address: _______________________________________

GENERAL INFORMATION

Please briefly explain why you are seeking counseling at this time?

On the scale below, please indicate how upsetting your problem(s) is/are right now:

❑ Mildly Upsetting ❑ Moderately Upsetting ❑ Very Upsetting
❑ Extremely Upsetting ❑ Totally Upsetting

When did your problem(s) begin? ____

Please describe any important events occurring at that time, or since then which may have started the problem(s) or which keep them going:

What solutions to your problem(s) have you found helpful?

What do you expect from therapy?

How many sessions do you think it will take to resolve the problem(s) that brought you counseling?

❑1-3 ❑4-6 ❑7-10 ❑10-15 ❑16-20 ❑over 20

❑Therapy will not resolve the problem(s)

If seeking individual counseling and the need arises, would other relative(s) be willing to come to therapy? ❑ Yes ❑ No

If no, please indicate the reason:

REFERRAL INFORMATION

Please explain how you heard about our office and how you were referred:

❑Friends ❑Agency ❑Pastor/Clergy ❑Relatives ❑Court System ❑Other: ___________

Reason for referral:

Have you (or anyone attending) ever been involved in therapy or any other type of counseling programs? ❑ Yes ❑ No

If yes, When?___________________ Where? ___________________________________

Reasons:

How would you describe your reaction to counseling?

❑ Satisfied ❑ Somewhat Satisfied ❑ Not Satisfied

Are you in treatment with another counselor at this time? ❑ Yes ❑ No

If yes, with whom? ____________________________ How long? __________________

PERSONAL HISTORY

Have you ever been hospitalized for any mental health reasons? ❑ Yes ❑ No

If Yes, When? ______________________ Where? _____________________________

By whom? ________________________________ How long? _________________

How much do you smoke? ___________________
How much do you drink and how often? ______________________
Do you think you, or anyone you live with, drinks too much? ❑ Yes ❑ No
Do you, or anyone you live with, use street drugs? ❑ Yes ❑ No How often? ________
If yes, please indicate what you are using: ___________________________________

Has you or anyone you live with, ever been treated for any type of chemical dependency abuse? ❑ Yes ❑ No If yes, when? ______________________________
Where? ________________________ Length of treatment? ___________________

Is there a history and/ or family pattern of:
❑ Physical Abuse ❑ Sexual Abuse ❑ Substance Abuse
❑Pornography Use ❑ Marital Affairs ❑ Imprisonment
Please explain:

Please indicate any of the following behaviors that apply to you or those seeking counseling (use initials to differentiate persons):

❑ High Blood Pressure
❑ Alcohol Problems
❑ Unusual Physical Symptoms
❑ Overeating
❑ Smoking
❑ Phobic Avoidance
❑ Outbursts of Temper
❑ Lack of Motivation
❑ Loss of Emotional Control
❑ Spiritual Concerns
❑ Work Too Hard
❑ Obsessions or Compulsions
❑ Marital Affairs
❑ Sleep Disturbances
❑ Take Too Many Risks
❑ Impulsive Reactions
❑ Depression
❑ Running Away from Home
❑ Fire-setting
❑ Epilepsy
❑ Drug Problems
❑Strange or Unusual Sensations
❑ Odd Behavior
❑ Crying, Vomiting
❑ Nervous Tic
❑ Insomnia
❑ Aggressive Behavior
❑ Procrastination
❑ Panic Attacks
❑ Suicidal Attempts
❑ Concentration Difficulties
❑ Withdrawal
❑ Can't Keep A Job
❑ Eating Problems
❑Pornography Use
❑ Legal Issues
❑ School Suspension/expulsion
❑ Frequent Relational conflicts

Are you presently under a physician's care for physical problems? ❑ Yes ❑ No

Please list any prescription ands/or herbal medications you are currently taking: ___________

____

Name of physician? ______________________________ Phone: ___________________

Have you ever been arrested and/or committed a crime? ❑ Yes ❑ No
If yes, please indicate when ___________________ For what: _______________________
Outcome of situation:

Are you or anyone you live with experiencing domestic violence/ feel unsafe?
❑ Yes ❑ No

Has your Bishop, Priest, or Clergy made a special effort to talk to you about your behavior or the behavior of a member of your family? ❑ Yes ❑ No

Have the police or other social agencies interfered in your family? ❑ Yes ❑ No

Has there been any other outside disturbances to your family? ❑ Yes ❑ No

Is there anything else you feel is important for me to know or understand about you, your family, or about the reason you are seeking counseling at this time? Please explain:

Person to contact in case of an emergency: ______________________________________

Telephone: _________________________ Relationship to you: ______________________

________________________________ ____________________________
Signature Date

________________________________ ____________________________
Signature Date

________________________________ ____________________________
Signature of Therapist Date

Confidentiality Policy

TO ALL CLIENTS:
If at any time you believe a concern arises in your treatment, please discuss it with me.

Please read the following information about the confidentiality policy and ask for clarification if necessary.

Every effort is made to ensure your complete privilege of confidentiality. Your treatment and all information pertaining to it will not be shared without your permission. You and your therapist may decide that gathering information from a third party will facilitate your current treatment. In that case you will be asked to sign a CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION form indicating the third party you give this therapist permission to contact. This Release of Information can be revoked at any time.

The following are a list of circumstances in which your privacy will be waived:

1. Reporting suspected child abuse, elder abuse or abuse of handicapped persons;
2. Reporting imminent danger to client or others;
3. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
4. Providing information concerning licensee case consultation or supervision; and
5. Defending claims brought by client against licensee;

In most cases, you will be informed that your confidentiality will be waived for one of the above reasons. In cases where there is a serious concern about increased risk, you may not be informed of the need to break confidentiality.

I have read and understand the above confidentiality policy.

______________________________ __________________________
Signature Date

______________________________ __________________________
Signature Date

______________________________ __________________________
Signature of Therapist Date