Family to Family Counseling Services
4110 NE 122nd Ave, Suite 102 Portland OR 97230

INTAKE INFORMATION:

Services can not be rendered with out the bold information being filled out correctly.

Client's Name: _____ Today's Date: _____
Age: _____ Birth date: _____Marital Status: _ Gender:_____
Street Address: _____
City: _____ State: ___ Zip Code: _____
Home/Cell Phone: _____ Work Phone: _____
May we leave a message for you at home: _____ work?_____
Email: _____

Spouses' Name: _____ (if applicable)
Age: _____ Birth date: _____Marital Status: _ Gender:_____
Address if different from above: _____
Telephone: _____ May I leave a message: _____
Email: _____

In the case that client is a minor, please state parent's name(s):
Mother: _____ Father: _____
Living Situation: _____
Others living at home (ages): _____
_____

INSURANCE INFORMATION:

Name of Insured Subscriber: _____ DOB (if different from above): _____
Employer: _____
Insurance Company: _____ Phone #: _____ Billing ID:_____
Insurance ID Number:_____Group Number_____
Billing address: _____ City/St/Zip:_____

CREDIT CARD INFORMATION:

I, _____, authorize _____ to charge my credit card for professional services as follows:
Please Initial:
_____ Recurring charges for services in the amount of $ _____ per visit.
_____ I understand and agree that my card will be charged a fee of $65 for cancellations with less than 24 hours' notice and for appointments I miss without notice as agreed to and signed in the Client Consent and Disclosure Form.
_____ This form is valid for one year unless I cancel the authorization in writing. I will not dispute charges ("charge back") for session I have received or appointments I missed according to the above policy.

☐ Visa ☐ MasterCard ☐ Debit Card

Card #: _____Expiration date: _____ Security Code: _____

Name as printed on Card: _____

Client Signature: _____ Date: _____

***SYMTOMS*:**

Please check all of the behaviors and symptoms that you consider problematic:

☐ Distractibility
☐ Hyperactivity
☐ Impulsivity
☐ Boredom
☐ Poor memory/confusion
☐ Seasonal mood changes
☐ Sadness/depression
☐ Loss of pleasure/interest
☐ Hopelessness
☐ Thoughts of death
☐ Self-harm behaviors
☐ Crying spells/tearfulness
☐ Loneliness
☐ Low self-worth
☐ Guilt/shame
☐ Fatigue
☐ Other: _____

☐ Change in appetite
☐ Lack of motivation
☐ Withdrawal from people
☐ Anxiety/worry
☐ Panic attacks
☐ Fear away from home
☐ Social discomfort
☐ Obsessive /compulsive behavior
☐ Relationships (marital)
☐ Aggression/fights
☐ Frequent arguments
☐ Irritability/anger
☐ Homicidal thoughts
☐ Flashbacks
☐ Hearing voices
☐ Visual hallucinations
☐ Grief

☐ Suspicion/paranoia
☐ Racing thoughts
☐ Excessive energy
☐ Wide mood swings
☐ Sleep problems
☐ Nightmares
☐ Eating problems
☐ Gambling problems
☐ Computer addiction
☐ Pornography
☐ Parenting
☐ Sexual
☐ Relationship
☐ Work/school
☐ Alcohol/drug use
☐ Recurring, disturbing memories
☐ Self-injury

Medical Conditions (X all that apply)

O Asthma
O Brain damage
O Migraine Headaches
O Multiple Sclerosis
O Possible Blood Dichasia
O Pregnancy
O Thyroid Condition

O Diabetes (not insulin dependent)
O Neurological Impairment
O Cancer
O Chronic Fatigue Syndrome
O Crohn's Disease
O Diabetes

O Lupus
O Fibromyalgia
O Heart Condition (significant)
O Hypertension
O Irritable Bowel
O Liver Disease

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious belies to be incorporated into you counseling? ☐ Yes ☐ No

Have you ever had any type of counseling prior to this time? Yes: ___ No: ___ If Yes, please explain: _____

_____

What the experience was like for you? _____

_____

Have you or any of your immediate family ever seriously considered or attempted suicide? Yes: ___ No: ___

If Yes, please explain: _____

RISK ASSESSMENT (Current):

Are you currently at risk to harm yourself (self-injurious behavior or suicide)? O Yes O No

Are you currently at risk to harm others (homicide, physical abuse)? O Yes O No

Are you currently at risk to be harmed by another person (physical abuse)? O Yes O No

Relevant family history (Past and present use of the following):

Cigarettes:_____ Alcohol: _____ Illicit Drugs: _____

Prescription and over the counter drugs: _____

Legal, family, occupation, physical problems due to substance abuse: _____

Emergency Contact: _____ Telephone: _____

Primary Care Physician Name: _____ Telephone: _____

***FAMILY DETAILS*:**

Please list the name, sex, birth date and age of each child presently living in the home:

Name	Sex	Birthday	Age

Please list the name, sex, birth date and age of each child presently living outside the home:

Name	Sex	Birthday	Age

Quality/age of relationships with:

Mother: _____ Father: _____ Stepmother: _____

Stepfather: _____ Siblings: _____ _____

(Siblings) _____ _____ _____

Spouse/Partner: _____ Children: _____

_____ _____ _____

Have you or any of your immediate family ever seriously considered or attempted suicide? Yes: ___ No: ___

If Yes, please explain: _____

_____

Have you or any member of your family ever been hospitalized for a mental health condition? Yes: ___ No: ___

If Yes, please explain: _____

_____

***INTAKE QUESTIONS*:**

Describe the problem(s) that brought you here today/ why now (Include any prior history of counseling for mental health, alcohol or other drug problems): _____

_____

_____

_____

_____

_____

How long has this been going on? _____

Which of these problems are you primarily responsible for and which are the responsibility of other persons? _____

_____

Who are these other persons? _____

What have you tried in the past to resolve this problem? _____

_____

Was it helpful? _____

What are effective coping strategies that you've learned? _____

_____

What strengths, talents, skills do you bring to the counseling process? _____

_____

_____

What do you hope to achieve through our time together? _____

_____

_____

Couples Counseling Questions:

How long have you and your partner been together? In what form (i.e. married, dating, living together)? _____

What initially attracted you to each other? How did you decide to get married or live together? _____

_____

_____

What do you find most fulfilling about your relationship?_____

_____

_____

What was the very beginning of your relationship like? How long did this phase last? _____

_____

_____

What was the first disillusionment? What happened and how did you resolve it? _____

_____

_____

_____

When do you feel least fulfilled in your relationship? _____

_____

_____

When do you feel most fulfilled in your relationship?_____

_____

_____

In what significant ways are the two of you similar? _____

In what significant ways are the two of you different? _____

What methods have you worked out to accommodate or compromise on your differences? _____

Do you spend time in activities away from your partner? If so, how often? _____

Do you spend time alone with people who are not mutual friends? Does this create conflict in your relationship?_____

How comfortable are you doing activities away from your partner? How comfortable are you with your partner doing things away from you? _____

How safe do you feel expressing your innermost thoughts and feelings to your partner? _____

How do you ask for emotional support from your partner when you are feeling vulnerable? Do you expect to get it? _____

Would your partner say that you are emotionally responsive to his / her vulnerability? Explain. _____

Do you take an active, energetic role in nourishing the relationship/ Does your partner do the same? How? _____

Do you support your partner's development as an individual? How (give example)? _____

Do you support his/her growth as an individual even when you don't agree? How (give example)? _____

How much do you believe your partner is giving to the relationship (i.e., 100%; 50%; 45%) _____

Do the two of you have joint commitments to projects, work activities, or social causes? If so, what? _____

Did you deliberately decide to create something together in one of these areas? _____

Does this project seem to add or distract from the bond between you? _____

_____

If your relationship were a drama, movie, or book, what would it be titled? How would it end? _____

_____

Mental Health Assessment

Appearance	☐ casual dress, normal grooming and hygiene ☐other (describe):
Attitude	☐ calm and cooperative ☐ other (describe):
Behavior	☐ no unusual movements or psychomotor changes ☐ other (describe):
Speech	☐ normal rate/tone/volume w/out pressure ☐ other (describe):
Affect	☐ reactive/mood congruent ☐labile ☐tearful ☐blunted ☐normal ☐depressed ☐Constricted ☐flat ☐ other (describe):
Mood	☐ euthymic ☐ irritable ☐ elevated ☐ anxious ☐ depressed ☐ other (describe):
Orientation	Oriented: ☐ time ☐ place ☐ person ☐ self ☐ other (describe):
Memory/Concentration	☐ short term intact ☐ long term intact ☐ distractible/inattentive ☐ other (describe):
Insight/Judgement	☐ good ☐ fair ☐ poor
Thought Processes	☐ goal-directed and logical ☐ disorganized ☐ other (describe):
Thought Content	**Suicidal** ideation: ☐ None ☐ Passive ☐ Active If active: plan: ☐ Yes ☐ No intent: ☐ Yes ☐ No means: ☐ Yes ☐ No **Homicidal** ideation: ☐ None ☐ Passive ☐ Active If active: plan: ☐ Yes ☐ No intent: ☐ Yes ☐ No means: ☐ Yes ☐ No ☐ delusions ☐ phobias ☐ other (describe):

DIAGNOSIS CODE AND SESSION TYPE:

☐ Individual (up to 60 minutes) (90834) ☐ Family Therapy with Client (90847) ☐ Diagnostic Interview (90791)

☐ Family without Client (90846) ☐ Group Therapy (90853)

TREATMENT PLAN

PRIORITIZED PROBLEMS:

1. _____
2. _____
3. _____

GOALS:

1. _____
2. _____
3. _____

Does patient understand proposed treatment plan? ☐ Yes ☐ No

If "no", please explain: _____

***Therapist Notes*:** _____

_____

_____

_____

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

☐ Yes ☐ No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

☐ Yes ☐ No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

☐ Yes ☐ No If yes enter 1 _____

4. Did you **often** feel that …

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If yes enter 1 _____

5. Did you **often** feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ Yes ☐ No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ Yes ☐ No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

☐ Yes ☐ No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

☐ Yes ☐ No If yes enter 1 _____

10. Did a household member go to prison?

☐ Yes ☐ No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score