

INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Marital Status:
 Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () - May we leave a msg? Yes No

Cell/Other Phone: () - May we leave a msg? Yes No

E-mail: _____ May we email you? Yes No

* Please be aware that email might not be confidential.

Referred by: _____

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

Yes No

Have you had previous psychotherapy?

No

Yes, Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?

Yes No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? Yes No

6. Do you regularly use alcohol? No Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage recreational drug use?

Daily Weekly Monthly Rarely Never

8. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had them in the past? Frequently Sometimes Rarely Never

9. Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood	Yes / No
Wild Mood Swings	Yes / No
Rapid Speech	Yes / No
Extreme Anxiety	Yes / No
Panic Attacks	Yes / No
Phobias	Yes / No
Sleep Disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/Substance Abuse	Yes / No
Frequent Body Complaints	Yes / No
Eating Disorder	Yes / No
Body Image Problems	Yes / No
Repetitive Thoughts (e.g., Obsessions)	Yes / No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	Yes / No
Homicidal Thoughts	Yes / No
Suicide Attempt	Yes / No

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<u>Difficulty</u>		<u>Family Member</u>
Depression	Yes / No	_____
Bipolar Disorder	Yes / No	_____
Anxiety Disorders	Yes / No	_____
Panic Attacks	Yes / No	_____
Schizophrenia	Yes / No	_____
Alcohol/Substance Abuse	Yes / No	_____
Eating Disorders	Yes / No	_____
Learning Disabilities	Yes / No	_____
Trauma History	Yes / No	_____
Suicide Attempts	Yes / No	_____

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

Alan Simberg Ph.D., LMFT, LCDC, ACN
2929 Allen Parkway
Suite 200
Houston, Texas 77019
Phone (281) 785-0660

TREATMENT INFORMATION AND CONSENT FORM

As your mental health services provider I will be giving you a copy of this document. It is designed to inform you about my background and to assure that you understand the nature of our professional relationship.

I hold a doctoral degree with a major in Counseling Psychology. I am state licensed in Texas as a Marriage and Family Therapist and as a Chemical Dependency Counselor.

During our first one or two sessions I will assess your challenges and tell you how I think I may be able to help you identify and implement solutions. I will include you in any decision that has to do with your treatment. You may end our professional relationship at any time. If you ever decide to do this I will be happy to help you to obtain another counseling provider at your request.

In order for you to obtain the greatest benefit from our sessions it is important to keep in mind that we have a professional relationship. This means that our sessions will focus exclusively on the resolution of your concerns and will avoid having any discussion or engaging in any behavior that could compromise your welfare and/or psychological well-being.

I will keep confidential anything that you say to me, with the following exceptions: (1) you direct me, either verbally or in writing, to tell someone else; (2) I determine that you are a danger to yourself or others, (3) a child or adolescent is in danger as may be, but not limited to, exposed to physical or sexual abuse or (4) I am ordered by a court to disclose specific information.

If at any time or for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your concerns to:

Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3193
1-800-832-9623

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. My sessions are 60 minutes in duration. Please note it is

impossible to guarantee any specific results regarding your counseling goals. However, I will do my best to assist you to achieve the best possible results.

**Alan Simberg, Ph.D. LMFT, LCDC Treatment Information And Consent Form,
Page 2**

In return for a fee of \$ ____ per session, I agree to provide my professional services, including evaluation and counseling services, to you. The fee for each session is expected to be paid at the conclusion of each session. Cash, personal checks or credit cards are acceptable forms of payment for my services. I will provide you with a receipt of all fees paid upon your request. In the event that you will not be able to keep an appointment, I request that you notify me 24 hours in advance. If I do not receive advance notice, if your cancellation does not allow someone else to be seen at your appointment time or if you regularly cancel your appointments you may be responsible for paying for the session that you missed.

If you wish to use your insurance to obtain reimbursement for my services, I will be happy to complete the forms to allow you to file with your insurance company for the services that I provide.

Not all health insurance companies will provide reimbursement for the counseling services you receive. Those that do reimburse usually require that a standard amount (i.e., known as your deductible) be paid by you before reimbursement is allowed. Then usually only a percentage of my fee is reimbursable. You will be responsible to pay my fee in full until the deductible is met and for obtaining and filing a claim form with your insurance company to receive reimbursement for the services that I provide.

Health insurance companies require that I diagnose your mental condition and indicate that you have an "illness" or condition before they will agree to reimburse you for your treatment. In the event that a diagnosis is required, I will inform you of the diagnosis that I will report to the insurance company before you submit it to your insurance company. Any diagnosis that I make will become a part of your permanent insurance records. If you have any questions about any of the foregoing information, please feel free to ask me. Please sign the attached form indicating that you have read and received this information from me.

Alan Simberg, Ph.D., LMFT, LCDC
2929 Allen Parkway
Suite 200
Houston, Texas 77019
Phone (281) 785-0660

Treatment Information And Consent Form

I have read the information in the Treatment Information And Consent Form given to me by Dr. Alan Simberg. I understand the information contained in this form and consent to abide by this agreement between myself and Dr. Alan Simberg.

Client Signature

Date

Parent, guardian or other signer

Date

Witnessed by:

Alan Simberg, Ph.D., LMFT, LCDC

Date