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 ☐a 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.):

Difficulty		Family Member
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?

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or the client's legal guardian. Noted exceptions are as follows:

DUTY to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____

Client Signature (Client's Parent/Guardian if under 18)

____

Today's Date

Alan Simberg, Ph.D., LMFT, LCDC, ACN
4802 Washington Avenue
Houston, TX 77007
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 relations.

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.

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, ACN
4802 Washington Avenue
Houston, TX 77007
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, ACN Date