Thriving Roots Counseling, LLC
(503)307-8966
SabrinaSheehyLCSW@gmail.com

Date: ____________

Name: ____________________________________ *Preferred Name* _______________________

Address: __________________________ *City:* ________________*State:* _____ *Zip Code:* _______

Cell Phone: ____________________ *Voicemail message ok? Yes* ☐ *No* ☐ *Text message ok? Yes* ☐ *No* ☐

*Other Phone (work, home, etc):*__________*Voicemail message ok? Yes* ☐ *No* ☐ *Text message ok? Yes* ☐ *No* ☐

Email: ____ ***Please note, email and text messaging will not be used for emergencies or crisis situations, as I may not be able to respond in a timely and effective manner through this form of communication. 911 or the Multnomah County Crisis Line is best: (503) 988-4888.*

Date of Birth: _____________________ *Gender/Pronoun Preference:*________________________

*Single*_____ *Partnership*_____ *Married*_____ *Separated*_____ *Divorced*_____ *Widowed*_______

Are you employed? Yes ☐ *No* ☐ *Occupation:* ____

Employer: ____ *Full or Part-time?* ______________

Are there any cultural identifiers that you feel are important for me to know about? Ie. Spiritual/Religious, Ethnic/Cultural, LGBTQ Community, etc.

____

Are you a Veteran or in the Armed Services? Yes ☐ *No* ☐

Primary Care Physician/Clinic: ____

Would you like to sign a release of information form for your doctor for coordination of care? Yes ☐ *No* ☐

Emergency Contact: ___________________________________ *Phone:* _____________________

Relationship to you: _____________* *This person may be contacted if you are at* <u>*imminent*</u> *risk of self-harm.*

Who referred you to me? ___________________ *May I thank them for the referral? Yes* ☐ *No* ☐ *n/a* ☐

Insurance Carrier: ________________________________ *Plan Name* ______________________

Id# ____ *Group #*___________________________

If you are not the primary insurance holder, please provide the <u>*name, relationship, and birthdate*</u> *of that person.*

Name: ________________________ *Relationship:*___________________ *Birthdate:*____________

Have you ever been to counseling/therapy before? Yes ☐ No ☐

Is there anything you would change about past therapy experiences? Is there anything that was helpful?

Do you have any medical conditions or health concerns?

Have you ever been hospitalized for mental illness-related issues? If yes, please briefly explain:

Are you currently taking any medications? Yes ☐ No ☐ If yes, please list name of medication, frequency of use & dosage:

Do you drink alcohol? Yes ☐ No ☐ If yes, how much and how often?

Do you smoke? Yes ☐ No ☐ If yes, how much and how often?

Do you use any other drugs or substances? Yes ☐ No ☐ If yes, what substance do you use, and how often?

Do you have a history of addiction or abuse of drugs, alcohol, or other related issues? Yes ☐ No ☐ If yes, have you received treatment (inpatient rehab, outpatient)?

Do any of your family members have a history of mental illness, drug, or alcohol abuse?

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Treatment Plan

Briefly describe why you are currently seeking therapy:

What are your goals for therapy? (Think of how life might look different if the above concerns were addressed. What would be the ideal result/s from engaging in therapy?)

Is there a specific style or approach to therapy that you prefer? (For example, are you looking for a directive problem-solving and solution-focused approach or do you need more of a processing experience?)

Any other thoughts on how I can help you?

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In the past month how often have you experienced the following symptoms?	Occasionally	Often	Daily
Extreme sadness			
Depression			
Lack of enjoyment in usual activities			
Feeling stressed			
Feelings of extreme happiness			
Low self-esteem			
Easily irritated			
Excessive worry			
Feeling keyed-up/ on-edge			
Feeling guilty			
Feeling nervous or anxious			
Feeling fearful			
Relationship difficulties			
Sudden feelings of panic			
Perfectionism			
Change in sleep habits			
Obsessions or compulsions			
Trouble performing at job/school			
Paranoid thoughts			
Reckless behavior			
Self-starvation			
Over-eating/ binge-eating			
Procrastination			
Indecisiveness			
Mind going blank			
Increased use of alcohol/drugs			
Crying spells			
Auditory hallucinations			
Visual hallucinations			
Avoiding things			

In the past month how often have you experienced the following symptoms?	Occasionally	Often	Daily
Feeling hopeless			
Apathy / lack of motivation			
Anger			
Grief			
Thoughts about self-harm			
Thoughts about harming others			
Suicide attempts			
Acting violently			
Homicidal thoughts			
Poor interpersonal skills			
Social awkwardness			
Isolation			
Somatic (physical) pains / discomfort			
Chronic pain			
Memory problems			
Trouble concentrating			
Lack of energy			
Change in appetite or eating habits			
Weight changes			
Muscle tension/aches			
Racing heartrate			
Intrusive thoughts			
Post-partum mood changes			
Exaggerated startle response			
Dizziness			
Feeling detached or distant			
Nightmares			
Changes in sexual interest			
Difficulty adjusting to recent life changes			

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Office Policies and Practices

Please read the following policies carefully and initial and sign where indicated. If you have any questions, please ask; I will be happy to discuss any questions or concerns you may have.

Professional Disclosure and Conduct

As an Oregon Licensed Clinical Social Worker and member of the National Association of Social Workers, my professional practice is governed by strict ethical guidelines, a copy of the Code of Ethics of my professional association can be provided on request, and/or any other information you may want to have concerning my experience, training, credentials, or counseling and therapy orientation. (Initial here after reading____)

Confidentiality

Our professional relationship is strictly protected by state and federal confidentiality laws. I am required to break confidentiality only when there appears to be a serious threat of harm to yourself or others, or when child or elder abuse or neglect is known or suspected, or if mandated by a judicial court order. Under no other circumstances will I release any information about you to another person or organization without your explicit, informed, and written permission. (Initial here after reading____)

Insurance, Fees, Payment, and Sliding Scale

The standard fee for each 50-minute individual counseling session is $120. The initial intake appointment (1st session) is $170. If for any reason, you are unable to afford the entire fee, please talk to me about a sliding scale rate that may be arranged until you are able to pay the full rate. If I am not on your insurance panel at this time I may be able to bill your insurance as an Out of Network Provider. If I am going to be billing your insurance, please call your insurance company to find out about your outpatient benefits for mental health. For credit card payments I currently use Square. If you decide to use a credit card for payment please indicate your consent to charge your card by signing below. (Initial here after reading ____)

Sliding Scale amnt: __________ Date: ___________

Signature for credit card authorization ___________________________________ Date: ________

Session Time, Appointments and Cancellations

Appointments are typically 50 minutes in length. If you arrive late, there is no discount for the shorter amount of time. Please give at least 24-hour's notice if you must cancel or reschedule an appointment; notice of less than 24 hours will, except in cases of emergency, result in a cancellation fee of half the session rate and no-shows (failure to appear for scheduled appointment without prior notice) will result in a charge of the full rate. (Initial here after reading_____)

Initial Sessions

A brief (30 minutes or less) phone consultation is available without charge upon request, to anyone considering counseling or therapy. These are informal meetings or telephone conversations for the purpose of answering questions you may have about professional services. If you decide to make an appointment for counseling the first few sessions will be used to gather basic information, clarify with you your goals for counseling and therapy, and develop with you a plan for working together. You have the right to terminate services. If at any time either of us feel that you would be best served by referral to another –or additional- service or helping professional, I will be happy to make a referral and to help make the connection. (Initial here after reading______)

Emergencies

I check my phone and text messages on every scheduled work day (currently: Mondays, Wednesdays, Thursdays, & Saturdays) and return every call at my earliest possible opportunity. If your call is urgent, I will do my best to get back to you immediately, but there are times when this will not be possible. If, during periods of time that I am away, you wish to have someone available to call on an emergency basis, I will be happy to refer you to one of my professional colleagues in my absence. Otherwise, if you need immediate assistance at any time, please call the Multnomah County Crises Line: (503) 988-4888. Please note that email and phone texts are not reliable mediums of communication for emergencies as I may not be able to respond in an effective or timely manner. (Initial here after reading ______)

Supervision

In order to provide you with the best quality care and service, I routinely meet with a clinical supervisor who consults with me on how I may continue to grow and improve my therapy skills. At times I need to refer to certain cases/clients during consults with the supervisor, although no names or identifying information about clients is being shared. In referring to certain cases, which may include yours, it is only in the spirit of seeking guidance and learning more about various clinical approaches that may be helpful, and for no other purpose. Again, your name and identifying information will not be disclosed to the supervisor or anyone. (Initial here after reading ______).

Privacy Practices/ HIPPA

You have the right to be made aware of your rights under the privacy act. I acknowledge that I may access my "Rights to Privacy" policies information via www.ThrivingRootsCounseling.com under the "Forms" tab. I may request a written copy of my "Rights to Privacy" policies information at any time. (Initial here after reading ______)

Attestation and Payment Agreement

I, (name:)____ have read and understand the above Office Policies and Practices statement concerning professional practices, payment, client/therapist responsibilities and other office policies. I agree to abide by my responsibility regarding cancellations and payment of fees, and consent to treatment as described and discussed with me. It is my responsibility to be aware of my insurance benefits and coverage of these sessions and I agree to pay any remaining balance not covered by insurance.

Name (please print:)____

Signature: ____ Date: ________

Parent Signature (if needed)___________________________________ Date: ________