Date: _____

Talk Amongst Yourselves, LLC

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Confidential Client Intake Form

Name: _____

Date of Birth: _____ Age: _____ Ethnicity:_____ Religion:_____

Gender Identity: _____Pronoun(s):_____Sexual Preference:_____

Marital/Relational Status: _____ Partner/Spouse Name: _____

Children (Names and ages):_____

Others living in your home: _____

Occupation: _____ Highest Level of Education: _____

Primary Care Physician (Name & Phone Number):_____

CONTACT INFORMATION

Address: _____ City/State_____ Zip_____

Phone number(s): (H)_____(C)_____

At which number(s) may I leave a message?_____

Email Address_____

EMERGENCY CONTACT (Parent/Guardian Contact – if under the age of 18)

Name: _____ Relationship to you: _____

Address: _____

Phone: (H)_____(C)_____-

Email:_____

***Please sign here to release information to them**_____

Date: _____

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EXPECTATIONS FOR THERAPY

What brings you to seek therapy now and what do you hope to gain?

(List 3 goals)_____

_____

_____

_____

What are your concerns about therapy? _____

_____

_____

PAST YEAR CHECKLIST

Only respond to those areas that apply to you. Please rate the level of distress these issues have caused you in the past year:

0 None 1 Minor 2 Moderate 3 Considerable 4 Extreme

____Sleeping Too Much/Too Little
____Eating Too Much/Too Little
____Mood Swings
____Angry Outbursts
____Depression
____Repetitive Behaviors
____Anxiety/Fear
____Lack of Energy
____Hear/See things others cannot
____Suicidal Thoughts/Actions
____Physical/Emotional/Sexual Abuse

____Drug/Alcohol (self or other)
____Loneliness
____Caring for Others
____Distance from Loved Ones
____Death/Major Loss
____Past Trauma
____Health Problems
____Sexual Problems
____Relationship Problems
____Concerns regarding family
____Education/Work Concerns

____Financial Concerns
____Legal Difficulties
____Major Life Transition
____Gender Identity Conflict
____Sexual Identity Conflict
____Cultural Concerns
____Religious Conflicts
____Experienced Discrimination

Date: _____

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MEDICAL AND MENTAL HEALTH TREATMENT INFORMATION

Please describe your physical health, including any major hospitalizations.

_____

_____

Are you currently receiving mental health services, (social worker, therapist, psychologist, or psychiatrist)?

Please include their **name and contact information**:

_____

_____

Please list your current medications and dosing:

_____

_____

_____

SUBSTANCE USE

Do you currently use tobacco, alcohol, cannabis, or street drugs? _____

Substance	Current- How much and how often?	Past Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If applicable) When you used the most, how much did you use? _____

_____

Previous substance abuse treatment?

LEGAL HISTORY

Are you involved in the legal system or have you had significant legal issues in the past?

_____

_____

_____

Date: _____

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TRAUMA HISTORY

Please list any past traumatic experiences you have had (including but not limited to childhood abuse, military combat, assault, natural disasters, life threatening illness).

_____

_____

Have you now or ever experienced violence, abuse, or threatening behavior in a relationship?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else you'd like me to know? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date: _____

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GENERAL INFORMATION REGARDING TREATMENT AND PAYMENT

- The initial visit and evaluation is 90 minutes. The cost is $250.
- Subsequent sessions will be 50/60 minutes. The cost is $150.
- Phone sessions and external forms billed per 1/4-hour
- Unfortunately, I do not participate with any insurance plans.
- You must be at least 18 years old to sign into treatment, or a parent or guardian must do so for you.
- Please attach a copy of your Drivers license or ID to this form
- Please read the HIPPA forms attached to the website. Your signature at the bottom acknowledges you have read and understood the HIPPA privacy agreement.

The sessions will be conducted in-person, or via password-protected Zoom meeting, on the device you choose. If you choose Zoom, you will receive an email invite for the session. Please arrange for a quiet, private space to have your Zoom session. Grab a cup of tea!

In-person details will be sent upon receipt of the intake documents.

Payment is expected at the time you book your first appointment, and prior to your start of each session after that. Payment services like Venmo, PayPal or credit cards (Square) are accepted. If you choose Square, please list the card information.

Kindly give 24 hour notice to cancel or change an appointment. Otherwise, you will be charged the full session fee.

Type of credit card, card #, expiration date, zip code and CVV#

Type_____#_____exp____/_____zip_____CVV_____

Or Venmo: @_____ PayPal: _____

I _____certify that all of the above information in this form is accurate. _____(date)

***All information in a session is confidential, unless it is determined that your emergency contact must be notified in order to keep you safe. Confidentiality will only be broken in cases of suicidal or homicidal ideation or child abuse, in order to keep all parties safe.**

I look forward to working with you, helping you to feel better and find a happier and healthier path.

Signature of Client_____

Signature of Guardian_____

Date_____

Kindly fax this form to 702-242-6027 or email to TalkAmongstYourselvesLV@gmail.com prior to your initial appointment.