Trailhead Counseling and Wellness, LLC
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Family Intake Form

Welcome! Please fill out the following form as accurately and legibly as possible. This will help me to understand your child better and support us in developing goals for counseling.

Parent(s) Name(s): _____Today's Date: _____

Home Address: _____

City, State, Zip Code: _____

Phone #: (_____) _____ - _____ Home Cell Work

Email Addresses: _____

_____

Relationship Status:

Single	**Married**	**Partnered**	**Divorced**	**Domestic Partner**	**Other**

How long have you been together? _____

Names and Ages of Children (if applicable):

Are there any children from a previous relationship or marriage? YES NO

If yes, please explain:

Please describe what brings your family to counseling at this time:

What does your family hope to accomplish through counseling? *(if different, please list separately)*

What has your family done already to cope with the challenges?

On a scale of 1-10, how much distress are you as a family experiencing today:

1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10

No distress Overwhelming Distress

Has anyone in your family had previous psychological counseling or psychiatric help?

- ❑ **YES**
- ❑ **NO**

If yes, when and where did was that counseling received and what were the circumstances? *(Individual, family, group, issues addressed, etc.)*

List any medications and dosage anyone is taking and for what health concern?

Please list any significant health problems that anyone in the family has been treated for or is currently being treated for:

What are your biggest strengths as a family? What do you do for fun and to relax?

Any current or past trauma in your family? **YES** **NO**

If yes, please briefly describe:

Please provide any significant information about family history and family psychiatric/mental illness history:

Do your family exercise? **YES** **NO**

What type of exercise? How often?

Does anyone smoke cigarettes? **YES** **NO**

Consume Alcohol? **YES** **NO**

How many drinks per day? _____

Use non-prescribed/recreational drugs? **YES** **NO**

Interactions between client and therapist are confidential. Unless I have specific permission from you, I will not discuss the content of our session with any outside parties. There are four exceptions to confidentiality that Oregon State Law requires mental health professionals to report.

1. Incidences of child or elder abuse
2. Intent to complete suicide
3. Threats to do harm to self or others
4. Court Order

Additionally, in the event of a billing dispute, names, dates, and lengths will be disclosed to a collection agency and/or attorney.

The community we live in can often feel small and the possibility that we may see each other outside of therapy is always present. Your confidentiality is priority in these situations. I will leave it to you if you would like to verbally or nonverbally recognize our encounter. I will follow your lead as I understand that everyone has different comfort levels when it comes to the privacy of their therapy.

If I am not able to make an appointment, I will cancel the appointment by phone or email with at least 24-hour notice. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the full session of the fee.

$100 per 50 minute session for individual and/or child/adolescent.
$125 per 75 minute session for families.

All fees are due at the time of service and can be paid by cash, check, or credit card *(Visa, Mastercard, Discover, American Express)*

My office is located at 780 NW York Drive, Suite 204. Suite 204 is a shared office space amongst multiple businesses. Please enter the door and have a seat in the open area between the offices. Please be respectful of other businesses while waiting for your appointment.

I have read and understand all aspects of this form and agree to the terms and conditions. By signing below, I am consenting to therapy and releasing Trailhead Counseling and Wellness, LLC/Andrew Krauthoefer, NCC, LSC, LPCi from any and all liability resulting from therapy. I am the party responsible for payment of services and will pay in full at the time of each therapy session. My signature below also confirms that I have received a copy of the "HIPAA Notice of Privacy Practices" and a "Professional Disclosure Statement" at the beginning of the first therapy session. I also understand I can view and download copies of both of the above at Andy's website: www.trailheadcw.com under the "forms" tab.

Printed Legal Name: _____

Signature: _____ Date: _____