Trailhead Counseling and Wellness, LLC
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Confidential Individual Intake Form

(to be completed if over 18)

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 Address: _____

Birthdate: _____ Identified Gender: Male Female

Relationship Status:

Single	Married	Partnered	Divorced	Domestic Partner	Other

Living Arrangement:

Alone	With Partner	With Kids	With Partner & Kids	With Family

Names and Ages of Children (if applicable):

Are you currently employed? **YES** **NO**

If so, what do you do for work? _____

If kids live at home part time or part time away from home, please describe arrangement:

Please describe what brings you to counseling at this time:

What do you/your child hope to accomplish through counseling? *(if different, please list separately)*

What have you and your child done already to deal with what is impacting them?

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

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

No distress Overwhelming Distress

Have you had previous psychological counseling or psychiatric help?

- ❑ **YES**
- ❑ **NO**

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

List any medications and dosage you are taking:

Please list any significant health problems that you have been treated for or are currently being treated for:

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

Any current or past trauma in your life? YES NO

If yes, please briefly describe:

Have you ever had thoughts of suicide or attempted suicide? YES NO

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

Do you exercise? YES NO

How many times per week? _____ For how long? _____

What type of exercise? _____

Do you 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.

$120 per 50 minute session for individual and/or child/adolescent.
$150 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:** _____