



# Intake Packet for New Clients

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## Informed Consent for Treatment

Welcome! I look forward to working with you. I know that starting counseling is a major decision and you may have many questions. The purpose of this document is to inform you about what you can expect from counseling and to give you the opportunity to give consent to proceed with the counseling process. We will discuss this during our first session.

My name is Kelly Hurley. I have a master’s degree in counseling; I am licensed by the state of Arizona BBHE (Board of Behavioral Health Examiners). I am a Cognitive-Behavior (CBT) therapist, with a special interest and expertise in Dialectical Behavior Therapy (DBT). I help people meet their goals by examining the connection between how they think, feel (emotionally and physically), behave, and interact with their surroundings. I facilitate growth and change in my clients by teaching mindfulness, thought defusion, emotion regulation, distress tolerance, and interpersonal effectiveness; and, I am EMDRIA Certified in Eye Movement Desensitization & Reprocessing (EMDR) for work with disturbing memories and trauma. I provide counseling, skills training, and consultation to individuals and groups.

*Please read this document carefully and mark each applicable box. We will discuss this document during our first session.*

- I am completing this consent for treatment for individual/couple counseling.  
Name \_\_\_\_\_
- I choose to participate in therapy services with Cedar & Oaks Counseling PLC

### Initials

\_\_\_\_\_ I understand that participating in these services is voluntary and collaborative, and that I may end services at any time. I agree to verbally advise Cedar & Oaks Counseling PLC when I decide to terminate services. I understand that, unless otherwise contracted, no contact for 30 days will result in file closure; my file may be reopened upon agreement by both parties.

\_\_\_\_\_ I understand that I will be participating in individual, couples, or family therapy services to address the issues and concerns that I share with my therapist. I understand that the focus of counseling services is on helping me reach my individual/couple/family goals. I understand that there are no guarantees that these services will make me or my partner/family members feel better or resolve my problems, issues, or concerns. Further, although I understand that counseling often results in positive outcomes, I also understand that the counseling process can open up levels of awareness that are painful (e.g. I could feel upset, anxious, angry, and/or uncomfortable).

\_\_\_\_\_ I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitations to confidentiality in cases when one or more of the following occur: **Intent to commit suicide; Intent to commit homicide; Any other act or intention to act in a way that may be a danger to self or others; Information regarding child or elder abuse that mental health providers are mandated by law to report; A court subpoena for records; Information regarding unprofessional conduct by another behavioral health professional.** In addition, I understand that my therapist is justified in informing an identifiable third party of risk of contagious/fatal disease.

\_\_\_\_\_ I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary, in order to ensure quality care.

\_\_\_\_\_ I understand that I have a right to request a copy of my record in writing. I understand that I also have the right to sign a written authorization that will allow Cedar & Oaks Counseling PLC to give and/or receive information verbally and in writing with individuals or entities that I designate. When in couple or family therapy all adults must sign the authorization/release of information form(s).

\_\_\_\_\_ I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however, I have the right to refuse treatment and to withdraw my informed consent for treatment by providing a written request. I understand that if I submit this request, Cedar & Oaks Counseling PLC will no longer be able to provide me with services.

\_\_\_\_\_ I understand that Cedar & Oaks Counseling PLC has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e. referral to another therapist or treatment provider).

\_\_\_\_\_ I understand that the therapy relationship is exclusively therapeutic (e.g. It is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that you (client) and I (therapist) are clear in our roles for treatment and that my confidentiality is maintained.

\_\_\_\_\_ I understand that electronic forms of communication (emails, website contact forms and text message) have risks that I need to consider before using with my therapist. Some of these risks are, but are not limited to: (1) being circulated, forwarded and stored in numerous paper and electronic files, (2) being immediately broadcast worldwide and be received by unintended recipients, (3) Senders can easily type in the wrong email address or phone number, (4) being easier to falsify than handwritten or signed documents, (5) having Backup copies that may exist even after the sender or the recipient has deleted his or her copy, (6) Employers and online services have a right to archive and inspect e-mails transmitted through their systems, (7) being intercepted, altered, forwarded, or used without authorization or detection, (8) being used to introduce viruses into computer systems, and (9) being used as evidence in court.

\_\_\_\_\_ I understand that my therapist cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If I prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, my therapist will do so. While my therapist may try to return messages in a timely manner, my therapist cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Instead use the **Maricopa Crisis Line at (800) 631-1314**

\_\_\_\_\_ I understand that my therapist knows the importance of confidentiality when it comes to Social Media. For my confidentiality and the importance of minimizing dual relationships, Kelly Hurley, LPC will not accept "friend request" or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc). I am aware that adding clients as friends or contacts on these sites can compromise my confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If I have questions about this, I understand that I can bring them up when I meet with my therapist and we can talk more about it.

\_\_\_\_\_ Kelly Hurley may be out of the office several times a year for several weeks at a time. I understand that she will provide me with ample notice and referral to a covering therapist during those times.

I/We have read and understand the above information and have discussed all aspects of informed consent with my/our therapist, Kelly Hurley. I/We hereby consent to receive counseling services from Cedar & Oaks Counseling PLC.

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Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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Kelly Hurley, LPC \_\_\_\_\_ Date \_\_\_\_\_  
A Member of Cedar & Oaks Counseling PLC

**Minor or Individual With A Guardian**

I/We, the parent(s) or guardian(s) of \_\_\_\_\_ have read and understand the above information and have discussed all aspects of informed consent with Kelly Hurley. I/We consent that \_\_\_\_\_ may be treated as a client by Cedar & Oaks Counseling PLC.

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Signature(s) of parent(s)/guardian(s) \_\_\_\_\_ Date \_\_\_\_\_

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Kelly Hurley, LPC \_\_\_\_\_ Date \_\_\_\_\_  
A Member of Cedar & Oaks Counseling PLC



- Cedar & Oaks Counseling PLC office line is NOT an emergency number. In the event of a psychological emergency, I may call the **Crisis line at (800) 631-1314**. In the event of a medical emergency, I should call **911** or to go to the closest emergency room. Otherwise I may leave a message and Kelly will get back to me as soon as possible. I understand that this may take 24 - 48 hours.
- I am financially responsible for any and all charges incurred for the treatment of the above-named client. I understand that I am held liable for any balance due on this account and that this balance will be due and payable on demand. I further understand that overdue accounts, with my name on them, may be submitted to a collection agency.

I have read and understand the above office policy regarding length of sessions, late arrivals, charges, returned checks, etc. I **agree to the stated terms.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Financially Responsible

\_\_\_\_\_  
Date



# Intake Assessment

Address: 7220 N 16<sup>th</sup> St Suite G • Phoenix, AZ 85020 • Tel (480) 707-8172  
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Please complete this form to the best of your ability. Please note "NA" when an item is not applicable to you.

## A. Identification and Contact Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender      F      M      Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

**All calls/e-mails will be discrete.**

Home Phone \_\_\_\_\_ May I leave a message?  Yes  No

Cell Phone \_\_\_\_\_ May I leave a message?  Yes  No

Work Phone \_\_\_\_\_ May I leave a message?  Yes  No

E-mail \_\_\_\_\_ May I e-mail you?  Yes  No

Marital Status:  Single     Married  Divorced     Separated     Widowed     Living Together

Sexual Orientation:  Heterosexual     Gay/ Lesbian  Other

Whom should I contact in an emergency?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## B. Referral

How did you come by my name? \_\_\_\_\_

If applicable, who suggested that you contact me? \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

How did this person explain how I might be of help to you?

**C. Reasons for Seeking Counseling.** Please describe the main difficulty that has brought you to see me. Is there a particular reason why you have decided to seek therapy now?

Have you been diagnosed by another mental health professional, either recently or in the past? If so, please note the diagnosis (and code if you know it) here.

What have you done to try to fix your problem? (e.g. other types of therapy, medication, self-help)

What was helpful? What wasn't helpful?

**Circle any problem that pertains to you at the present:**

- |              |                    |                   |            |
|--------------|--------------------|-------------------|------------|
| Nervousness  | Relaxation         | Making Decisions  | Stress     |
| Shyness      | Legal Matters      | Self Control      | Memory     |
| Separation   | Energy             | Inferiority       | Appetite   |
| Drug Use     | Loneliness         | Bowel Troubles    | Marriage   |
| Anger        | Education          | Sexual Problems   | Work       |
| Sleep        | Undereating        | Alcohol Use       | Overeating |
| Friends      | Concentration      | Nightmares        | Temper     |
| Fatigue      | Ambition           | Stomach Problems  | Divorce    |
| My thoughts  | Parenthood         | Health Problems   | Age        |
| Finances     | My Appearance      | Suicidal Thoughts | Future     |
| Sexual Abuse | Children           | Career Choices    | Weight     |
| Unhappiness  | Depression         | Headaches         | Fears      |
| Self-esteem  | Sexual Orientation | Physical Abuse    |            |

**Anything else that you don't see listed here?**

**Circle everything that has happened to you in the past three years:**

- |                                       |                                     |                               |
|---------------------------------------|-------------------------------------|-------------------------------|
| Death of a spouse/partner             | Marriage Problems                   | Changes in marital status     |
| Death of another family member        | Family Problems (Children, in-laws) | Loss of Job                   |
| Major illness or injury–yourself      | Financial Problems                  | Move to another city or state |
| Major illness or injury–family member | Legal Problems                      | Other: _____                  |

**Please list any additional information that you believe may be helpful or that you want me to know:**

What are your interests and hobbies?

What emotions do you have trouble with? How do you deal with them?

What relationships do you struggle with? How do you deal with those difficult relationships?

Who in your life do you consider supportive?

What kinds of skills do you think you might need help with; skills that will help you meet your counseling goals?

### **D. Education, Work, Military**

If you are currently going to school, where? What are you studying?

High School degree? Year graduated \_\_\_\_\_

OR

GED? Year obtained \_\_\_\_\_

Other education and degrees including trade schools:

School/Degree

Focus of Study

Year Completed/Graduated

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Place of Employment: \_\_\_\_\_ How Long? \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

If not employed, how long has it been since you worked? \_\_\_\_\_

What kind of job did you have? \_\_\_\_\_

What caused you to stop working? \_\_\_\_\_

What other types of work have you done in the past?

Have you ever been or are you now in the military?  Yes  No

## E. Relationships

Please list current and past marriages or significant romantic relationships.

To Whom	Length of Relationship (approximate dates)	Children From Relationship? (names & ages)	Reason Relationship Ended

**If currently in a relationship:**

Briefly describe nature of relationship \_\_\_\_\_

Partner's Age: \_\_\_\_\_ Religion: \_\_\_\_\_

Education, degrees? \_\_\_\_\_ Occupation: \_\_\_\_\_

Is partner currently employed?  Yes  No How Long? \_\_\_\_\_

Has your partner been previously married?  Yes  No Number of times: \_\_\_\_\_

How long since partner's last marriage? \_\_\_\_\_

Number of children from partner's previous marriages: \_\_\_\_\_ Ages of partner's children: \_\_\_\_\_

**With whom are you currently living? Include pets!**

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol/Drugs Mental Illness or Other Problems (note here if person is no longer living)

**Siblings, Parents, Extended Family, Friends, Children & Step Children (not already listed)**

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol/Drugs Mental Illness or Other Problems (note here if person is no longer living)

Where did you grow up? If not in Phoenix, when and why did you move to the Phoenix area? How was it to grow up in your family?

## F. Medical/Physical Information

From whom or where do you get your medical care?

Clinic/Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Has your doctor ruled out any medical cause for the symptoms you are here about?  Yes  No

List any health problems for which you currently receive treatment: \_\_\_\_\_

List any past health problems including accidents: \_\_\_\_\_

List any non-psychiatric medications you currently take and for what reason: \_\_\_\_\_

### Women only:

How many pregnancies have you had? \_\_\_\_\_ Are you pregnant now?  Yes  No

How many live births? \_\_\_\_\_

Any miscarriages?  Yes  No How many? \_\_\_\_\_

Any changes in your menstrual cycle? \_\_\_\_\_

### Men and women:

Are you sexually active?  Yes  No \_\_\_\_\_

Do you use birth control methods?  Yes  No

Do you practice safe sex?  Yes  No

Have you ever been concerned about your eating habits?  Yes  No If yes, briefly describe your concerns:

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_ What do you do?

How do you sleep? Any concerns?

Is there anything else about your physical health that you want me to know?

**G. Mental Health**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

Yes  No If yes, please indicate:

When?	From Whom?	For What?	With What Results?

Do you now or have you ever taken medications for psychiatric or emotional problems?  Yes  No

If yes, please indicate:

When	Prescriber	Medication	For What?	Results

Are you thinking about suicide now?  Yes  No

Have you thought about suicide in the past?  Yes  No

Have you ever attempted suicide?  Yes  No

If yes for any of the above 3 questions, please indicate: when, why, how (how did you try to kill yourself), and what happened (treatment, hospitalization, consequences, etc.) (use a separate piece of paper if needed)

Do you now, or have you ever engaged in self-harm (e.g. cutting, burning, or hurting yourself in any way) or other potentially damaging or impulsive behaviors (e.g. unsafe sex practices, gambling, impulsive spending)?

Yes  No If yes, please describe. Include history, frequency, the last time you engaged in the behavior(s), and anything else you think it would be important for me to know. (use a separate piece of paper if needed)

Are you now, or have you ever been, the victim of any kind of abuse (emotional, physical, sexual)?  Yes  No If yes, please explain: (use a separate piece of paper if needed)

## **H. Spiritual/Religious Beliefs/Practices. Please answer any or all of the following questions:**

Is religion or spirituality important to you?

Do you consider yourself a spiritual person?

Do you believe in a higher power?

Are you affiliated with any particular religion or place of worship? If so, what is it? What gets you through difficult periods in your life?

What brings you hope and joy?

**I. Substance Use**

Do you believe you have a drug or alcohol problem?      Currently     Yes    No  
In the past     Yes    No

List all tobacco, marijuana, non-prescribed drugs, and alcohol, that you currently use or have used in the past (indicate frequency and amount):

Type	First Used	Last Used	Amount/Frequency

**J. Legal** Please list and describe any arrests or legal problems: