



BRIEF INTAKE

Name: _____ DOB: _____ Phone: _____

Physical Address: _____

Email address: _____

Emergency Contact: _____

Are you utilizing your **Insurance** or **Employee Assistance Program**? _____

Insurance Info:

Employment Info:

Carrier/Provider: _____

Employer: _____

Name if Insured: _____

Job Title: _____

Policy/Group# _____

+/-, hrs/yrs: _____

Relationship(s): single married in a monogamous relationship open relationship divorced separated dating
Children? _____ ages _____

Who you currently live with and a few words describing your home environment:

Presenting Concern(s).

Recreational activities:

Working Out Movies Going Online (FB, twitter, research, streaming, browsing,etc) Gambling Camping
Bowling Going Out Dancing Cooking Sewing Reading,
... _____

Current Strengths and Resources (including skills or hobbies that you love and/or feel nourished by.. and also include your supportive communities and family):

Therapy Goals (what you'd like to see change as a result of participating in therapy):

Please list any Medications you are taking: _____

Any other Providers you are currently seeing. (ROI ?)



COMPREHENSIVE INTAKE

Client's Name: _____ Today's Date: _____

Age/Date of Birth: _____ Home Address: _____

City/State/Zip: _____

Cell Phone: _____ Is it okay to leave a confidential message? Yes/ No

Email address: _____ Is your email confidential? Yes/No

Emergency Contact

	()	
Name	Relationship	Phone

Who do you live with? _____

What **Culture** you most identify with _____

How would you define your sexuality? _____

Describe your Spiritual Practice/ Religious Affiliation: _____

Are you currently in school? If so, where and what do you study? _____

Are you currently Employed?: _____ Looking? _____ Job Title/Task(s): _____

Do you like your job? _____

Are you able to utilize either **Insurance** or **EAP** (Employee Assistance Program) to cover therapeutic services? Name of Employer/Company your insurance is under: _____

*Insurance Carrier: _____ Name of Insured: _____ Insured's Policy & Group#: _____

*If you are **not** utilizing insurance, please indicate that you acknowledge the fee of \$115 per session due at the time of service.

___ Yes, I understand.

___ No. Please explain and provide your suggested alternative: _____

Please briefly explain what you look forward to addressing in therapy:

How long has this/these been a concern? _____

To what degree does it affect your ability to function on a daily basis? ...Explain

1 2 3 4 5 6 7 8 9 10

Hardly Intensely Severely _____

In what ways have you tried to manage these concerns in the past? (e.g., therapy, medications, respite, drugs/alcohol, family interventions, mediation, etc)?

...



Do you currently have a prescribing physician for psychiatric medication?

Name of Doctor/Clinic: _____ Contact Number: _____

Date of last appointment or contact with your doctor: _____

Do you see any **other** health care providers?

Chiropractic Naturopath Acupuncture Bio-feedback Massage Other :

Do you have any allergies? If so, please list them.

List any Prescription Medications currently taking (include name, dosage, and frequency)

Please list any over the counter medication, vitamins, sleep aids, other supplements you use..._____

Family Information

Describe your family in one or two words: _____

Current Marital Status: Married Divorced Separated "open" Single Other:_____

Spouse/ Partner's Name: _____ Age:_____

Children (Include all biological, adopted, foster, step, or grand-):

Name Sex Age (b,a,f,s or g) Custody & a brief statement about your relationship

				Y / N	
				Y / N	
				Y / N	
				Y / N	

Please identify and explain any current family/relationship/ environmental/ personal **stressors** that seem relevant to your difficulties. _____

Biological **Mother**: _____ Describe your relationship: _____

Step-Father/Mother: _____ " : _____

Biological **Father** : _____ Describe your relationship: _____

Step-Mother/Father: _____ " : _____

Who were your primary Caregiver(s) growing up? _____

List your siblings (if any), their ages, and briefly describe your relationships with them:

Where were you born and raised (include significant moves, changes and transitions)?



Was your childhood impacted by alcohol/drugs, mental illness, criminal activity or violence?

- ___ Medical problems or concerns If yes, what/who? _____
- ___ Aggression, Oppositional Behavior If yes, who? _____
- ___ Attention, Hyperactivity, Impulsiveness If yes, who? _____
- ___ Psychosis, Schizophrenia If yes, who? _____
- ___ Mood Problems, Depression If yes, who? _____
- ___ Anxiety Problems, Excessive Worrying If yes, who? _____
- ___ Substance Abuse If yes, who/what? _____
- ___ Legal Problems If yes, who/what? _____
- ___ Suicide, Self-harm If yes, who/**when**? _____

Have you experienced significant losses in your life? If so, what or whom and when?

Did you experience **childhood** neglect, emotional abuse, physical abuse and/or sexual abuse?

Which one(s)? _____ Please share as many details as you feel comfortable giving at this time:

Did you receive any support for any of the above? If not, what happened? And if so, from whom?

Beyond childhood (as an **adult**), have you experienced any other violence or have you been harmed physically, sexually or emotionally? If so, please briefly explain. _____

Please describe any support you received and from whom. _____

Describe your FRIENDSHIPS, COMMUNITY, & SPIRITUALITY

Describe your current living situation? _____

_____ How long? _____ Any recent changes? _____

Risk Factors and Brief Safety Assessment

Circle all that you are experiencing currently: feeling worthless feeling hopeless
irritable trouble sleeping angry outbursts withdrawing from social/family isolation
using drugs and/or alcohol increased sexual encounters frequent thoughts of suicide or self-harm

What are your biggest **current** stressors? _____

History of self harm, cutting, or suicidal behavior? **Yes/No** Family history of suicide? **Yes/No**
Safety Plan... (What you would do to feel safe if you started having increased suicidal thoughts)



Lifestyle/ Habits:

Estimate how many hours/day you spend online...

Facebook _____, YouTube _____, Twitter _____, Internet gaming _____, research _____, working _____, browsing _____, porn _____, streaming TV/movies _____, and other: _____

Habits	Age when 1 st began using...	Times/ week	Current or Past
Caffeine-soda/coffee			
Cigarettes, cigars, etc			
Rx Medications			

Describe your diet (when and what you eat/consume on a daily basis):

Breakfast _____

Lunch _____

Snack(s) _____

Dinner _____

Substance Use/ Abuse History...

Substance <small>(pot, coke, meth, shrooms, pills (oxy), inhalants, hallucinogens, etc...)</small>	Age when 1 st began experimenting with...	Amount/ Frequency (e.g.: one bowl/ 3x a day...)	Date of Last Use
Alcohol			

What gives you the most joy or pleasure in your (Client's) life?

Please list some of your strengths and talents.

What are your primary worries or fears?



Are you satisfied with your Relationship and/or sex life?

What are your most important hopes and dreams?

How do you like to spend your free time?

If Ct is a child, please list any significant (positive or challenging) events and developmental milestones. For example; was very colicky, age started walking/talking, fussy eater, separated from caregiver easily or not, was bit by dog, etc.

Therapy GOALS: Please summarize what you would like to see change as a result of coming to therapy at this time.

Thank you. And feel free to make any other comments, questions or to express further concerns here.



PROFESSIONAL DISCLOSURE STATEMENT

My Philosophy and Approach: I believe that everyone has strengths and abilities that make us each special and resilient. A positive environment and nurturing relationships are ideal conditions to grow and heal. My goal is to tend to each of my client's needs with holistic and nurturing attention while providing a safe, confidential space for important transformations to develop. My approach is client-centered and strengths-based. I work with the individual, couple and/or family to incorporate obtainable and realistic goals and often use art therapy interventions as an avenue for expression and exploration.

My Credentials and Training: My undergraduate training was from Gonzaga University and I hold BAs in psychology and art. I have also earned a MA in Art Therapy & Counseling (ATR) from Marylhurst University. I am trained to utilize both Art and Talk Therapy. Major areas of study included human development, ethics, assessment and treatment, the counseling process, family therapy and the uses of art in the therapy process and addiction counseling. I have earned my Certification in Alcohol and Drug Counseling (CADC-I) and my License as a Professional Counselor (LPC). I constantly attend trainings and workshops to maintain current knowledge of issues, research, ethics and helpful approaches in my field. My continued studies have had a significant focus on attachment, trauma and relationships. I also participate in clinical supervision and consultation monthly. I commit to attending and learning more about interpersonal neurobiology, mindfulness practices and the enneagram. I believe that everyone has the strengths and abilities necessary to achieve resilience and that a positive environment and nurturing relationships are ideal conditions to grow and heal.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I will abide by its **Code of Ethics**. In case any ethical concerns or questions arise, please feel free to ask me directly. You may also always contact the Oregon Board of Licensed Professional Counselors at 3218 Pringle Rd SE, #250 Salem, OR 97302-6312. Telephone: (503) 378-5499.

Art Therapy: Art Therapy is more than simply doing art; however, doing art is healing in and of itself. Art Therapy is a process. Exploring with and manipulating art materials allows us to gain insight into our own thoughts and feelings. Often how one interacts with the materials might reflect similar patterns present when interacting with life and within relationships. Exploring through art provides an opportunity to process, organize and reshape feelings and thoughts. It is from these expressions we can work together to find the underlying needs.

Payment for Services: The initial consultation is FREE! The fee for individual sessions is \$120 and for couples or family therapy, the fee is \$140. As I work towards getting on Insurance companies' provider lists, mine is currently a direct fee-for-service and I accept payments in credit/debit cards, cash or check. I do offer sliding scale fees depending on availability and on your financial situation and comfort.

Appointments: The usual session time is 50 minutes. In event of late arrival, the session will still end at the regular time and you will be charged for the full session fee. If you are going to be unable to keep an appointment, please contact me at least 24 hours ahead of time. Without notice, and with the exception of a medical emergency, you will be charged for your session fee for the missed appointment. Cancellation less than 24 hours will result in a \$50 late cancellation fee.



CONFIDENTIALITY AND CONSENT FOR TREATMENT

Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. Your Rights and the exceptions to confidentiality are explained below:

CLIENT’S RIGHTS

As a client of an Oregon licensee, you have the following rights:

- *To expect that a licensee has met the minimal qualifications of training and experience required by state law.
- *To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- *To obtain a copy of the Code of Ethics;
- *To report complaints to the Board;
- *To be informed of the cost of services before receiving services;
- *To be assured of the privacy and confidentiality while receiving services as defined by rule and law, including the following **EXCEPTIONS:**
 - 1) Reporting suspected child abuse;**
 - 2) Reporting imminent danger to client or others;**
 - 3) Reporting information required in court proceedings or by client’s insurance company, or other relevant agencies;**
 - 4) Providing information concerning licensee case consultation or supervision;**
 - 5) Defending claims brought by client against licensee;**
- *To be free from being the object of discrimination on the basis of race, Religion, gender, or other unlawful category while receiving services.

Emergency Procedures: In the event of an emergency, first call the Multnomah Co. Crisis Line at (503) 988-4888 or 911 if there is immediate danger or threat. Then, my direct number is (503) 502-8593 and I messages from 8am to 7pm on weekdays and once a day on weekends and holidays. If unable to reach me, the county, OR a crisis response worker, and your conditions progress- please go to your nearest hospital or emergency room.

Consent to Treatment

I have read and understand my rights and responsibilities as outlined in the Informed Consent for Treatment and Evaluation form. By signing this form, I also consent to receive Mental Health Services and/or Chemical Dependency Services to be provided by Christina Zimmerman, ATR, LPC, CADCI

Client _____ date _____

Parent or Guardian (if minor) _____ date _____

_____ date _____

(witness) *Chrissy Zimmerman, LPC, ATR, CADCI*



FEE AGREEMENT

My goal is to make counseling accessible for anyone who feels they would benefit.

° My standard fee for individuals paying by cash or check is \$120 for a 50-minute session. If a different fee is needed, Client and Therapist will agree on that fee and identify below.

° Services are paid privately by cash, check or card at the time of the session.

° If you are utilizing your insurance benefits, but have not yet made your deductible, my standard rate will be charged until your deductible is met. At that point we will work with the contracted rate and copayments outlined by your specific benefit.

° The fees associated with counseling are your responsibility.

° Refunds are not available.

° If unable to make an appointment, 24-hour notice is required. If 24-hour notice is not given, a \$50 Session Fee charge will be assessed.

° If client does not show for an appointment, the Full Fee will be assessed.

° Services may be terminated at any time, for any reason by either client or therapist.

° I may refer you to another provider - it is your responsibility to arrange an appointment with that provider.

Fee for Services as agreed by clinician and client: _____ per 50-minute session

Client: _____ Date: _____

Guardian/Parent (if under 18): _____ Date: _____

Therapist: _____ Date: _____

