

# Roseway Counseling Services

150 South East 80<sup>th</sup> Ave  
Portland, Oregon 97215  
(503) 320-0762

S Elizabeth Limbocker, LMFT

## INTAKE INFORMATION

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Religion (opt.): \_\_\_\_\_

Type of Employment: \_\_\_\_\_

Name of Additional Person(s) to be involved in counseling:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is okay to leave a message on my phone. If not, message number: \_\_\_\_\_

How shall we identify ourselves? \_\_\_\_\_

You may send mail to the above address.

Please send mail to this address: \_\_\_\_\_

## GENERAL INFORMATION

Please briefly explain why you are seeking counseling at this time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

On the scale below, please indicate how upsetting your problem(s) is/are right now:

Mildly Upsetting  Moderately Upsetting  Very Upsetting  Extremely Upsetting

Totally Upsetting

When did your problem(s) begin? \_\_\_\_\_

Please describe any important events occurring at that time, or since then which may have started the problem(s) or which keep them going:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What solutions to your problem(s) have you found helpful? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What do you expect from therapy? \_\_\_\_\_

\_\_\_\_\_

How many sessions do you think it will take to resolve the problem(s) that brought you counseling?

- 1-3 4-6 7-10 10-15 16-20 over 20 Therapy will not resolve the problem(s)

If seeking individual counseling and the need arises, would other relative(s) be willing to come to therapy?  Yes  No

If no, please indicate the reason: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**REFERRAL INFORMATION**

Please explain how you heard about our office and how you were referred:

- Friends Agency Pastor/Clergy Relatives Court System Other: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

\_\_\_\_\_

Have you (or anyone attending) ever been involved in therapy or any other type of counseling programs?  Yes  No

If yes, When? \_\_\_\_\_ Where? \_\_\_\_\_

Reasons: \_\_\_\_\_  
\_\_\_\_\_

How would you describe your reaction to counseling?

Satisfied  Somewhat Satisfied  Not Satisfied

Are you in treatment with another counselor at this time?  Yes  No

If yes, with whom? \_\_\_\_\_

How long? \_\_\_\_\_

**PERSONAL HISTORY**

Have you ever been hospitalized for any mental health reasons?  Yes  No

If Yes, When? \_\_\_\_\_

Where? \_\_\_\_\_

By whom? \_\_\_\_\_ How long? \_\_\_\_\_

How much do you smoke? \_\_\_\_\_

How much do you drink and how often? \_\_\_\_\_  
\_\_\_\_\_

Do you think you, or anyone you live with, drinks too much?  Yes  No

Do you, or anyone you live with, use street drugs?  Yes  No

If yes, how often? \_\_\_\_\_  
\_\_\_\_\_

If yes, please indicate what you are using: \_\_\_\_\_  
\_\_\_\_\_

Have you or anyone you live with, ever been treated for any type of chemical dependency abuse?  Yes  No

If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

Length of treatment? \_\_\_\_\_

Is there a history and/ or family pattern of:

- Physical Abuse  Sexual Abuse  Substance Abuse
- Pornography Use  Marital Affairs

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate any of the following behaviors that apply to you or those seeking counseling (use initials to differentiate persons):

- High Blood Pressure \_\_\_\_\_  Epilepsy \_\_\_\_\_
- Alcohol Problems \_\_\_\_\_  Drug Problems \_\_\_\_\_
- Depression \_\_\_\_\_  Strange or Unusual Sensations \_\_\_\_\_
- Overeating \_\_\_\_\_  Odd Behavior \_\_\_\_\_
- Smoking \_\_\_\_\_  Crying \_\_\_\_\_
- Vomiting \_\_\_\_\_  Legal Problems \_\_\_\_\_
- Phobic Avoidance \_\_\_\_\_  Nervous Tic \_\_\_\_\_
- Outbursts of Temper \_\_\_\_\_  Insomnia \_\_\_\_\_
- Lazy \_\_\_\_\_  Aggressive Behavior \_\_\_\_\_
- Loss of Control \_\_\_\_\_  Procrastination \_\_\_\_\_
- Spiritual Concerns \_\_\_\_\_  Drink Too Much \_\_\_\_\_
- Work Too Hard \_\_\_\_\_  Suicidal Attempts \_\_\_\_\_
- Compulsion \_\_\_\_\_  Concentration Difficulties \_\_\_\_\_
- Marital Affairs \_\_\_\_\_  Withdrawal \_\_\_\_\_
- Sleep Disturbances \_\_\_\_\_  Can't Keep A Job \_\_\_\_\_
- Take Too Many Risks \_\_\_\_\_  Eating Problems \_\_\_\_\_
- Impulsive Reactions \_\_\_\_\_  Pornography Use \_\_\_\_\_
- Unusual Physical Symptoms \_\_\_\_\_

Are you presently under a physician's care for physical problems?  Yes  No

Please list any prescription medication you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been arrested and/or committed a crime?  Yes  No

If yes, please indicate when \_\_\_\_\_

For what: \_\_\_\_\_

Outcome of situation: \_\_\_\_\_

\_\_\_\_\_

Are you or anyone you live with experiencing domestic violence/ feel unsafe?

Yes  No

Has your Bishop, Priest, or Clergy made a special effort to talk to you about your behavior or the behavior of a member of your family?  Yes  No

Have the police or other social agencies interfered in your family?  Yes  No

Have there been any other outside disturbances to your family?  Yes  No

Is there anything else you feel is important for us to know or understand about you, your family, or about the reason you are seeking counseling at this time?

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Person to contact in case of an emergency: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

# Confidentiality Policy

**TO ALL CLIENTS:**

**If at any time you believe a concern arises in your treatment, please discuss it with your therapist.**

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Please read the following information about the confidentiality policy and ask for clarification if necessary.

Every effort is made to ensure your complete privilege of confidentiality. Your treatment and all information pertaining to it will not be shared without your permission. You and your therapist may decide that gathering information from a third party will facilitate your current treatment. In that case you will be asked to sign a CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION form indicating the third party you give this therapist permission to contact. This Release of Information can be revoked at any time.

The following are a list of circumstances in which your privacy will be waived:

- 1. Reporting suspected child abuse, elder abuse or abuse of handicapped persons;
- 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; and
- 5. Defending claims brought by client against licensee;

In most cases, you will be informed that your confidentiality will be waived for one of the above reasons. In cases where there is a serious concern about increased risk, you may not be informed of the need to break confidentiality.

I have read and understand the above confidentiality policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date