Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

New Client Intake/Assessment Form

Client's Name _____ Date _____

If Client is under 18-years-old, Parent/Guardian Name _____

Contact Information

Address of Responsible Party _____

City _____ State _____ Zip Code _____

Email address: _____

Phone: Client Cell _____ Parent/Guardian (If under 18) _____

Do we have your permission to leave a voice message? Yes No

Do we have your permission to send a text message to your cell phone? Yes No

Do we have your permission to contact you via email? Yes No

Client Information: Client's Name _____

Age _____ DOB _____ Gender: Male Female

Employer/School _____ Occupation _____

Indicate last year of school/diploma/degree completed: _____

Military Service: Yes No If yes, are you active duty/reserve duty/discharge date: _____

Marital Status: Single Engaged Cohabitating ___years Married ___years Widowed Separated

Divorced Total number of marriages for you _____ For partner _____

Family Information: Parent/Partner/Spouse's Name _____

Age _____ DOB _____ Gender: Male Female

Employer/School _____ Occupation _____

Indicate last year of school/diploma/degree partner has completed: _____

Partner's Military Service: Yes No If yes, is partner active duty/reserve duty/ discharge date: _____

Please list children by name, gender, age, and living situation: (If more than four please list on back of this form)

Name _____ M F Age _____ At Home On Own With Someone Else

Name _____ M F Age _____ At Home On Own With Someone Else

Name _____ M F Age _____ At Home On Own With Someone Else

Name _____ M F Age _____ At Home On Own With Someone Else

Please list others currently living in the home _____

Are you caring for someone in your home that is ill or disabled? Yes No

Emergency Contact:

Name _____ Phone _____ Relation _____

Counselor's Name: Diana Hassani Emily Wright Other

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

New Client Intake/Assessment Form

Client's Name _____ Date _____

Current Concerns

Purpose of this visit _____

How long has client had the problem for which he/she is seeking help? _____

Briefly state the nature of the problem as he/she sees it? _____

_____

_____

Medical Information

Family Physician _____ Date of Last Visit _____

Psychiatrist/Psychologist: _____ Date of Last Visit _____

Do you have a serious and/or chronic medical condition, such as diabetes, cancer, heart disease, thyroid disease, asthma, rheumatoid arthritis, etc.? Yes No If yes, please describe current medical condition(s) _____

_____

List Current Medications _____

_____

In the past six months how many times has client seen a medical doctor? 0 1 2-3 4-5 6+

In the past 30 days, how much have you been bothered by physical pain? None Some Moderate Quite Extreme

Counseling History

Are you currently working with any other counselor/psychologist/psychiatrist? Yes No

If yes, Name _____ Location _____

Have you previously had professional counseling for any reason? Yes No

List prior counseling, therapy, and hospitalizations for emotional and/or mental health issue: Reason/Date/Location

_____

_____

_____

Who referred you to Alpha Omega Delta? _____

Counselor's Notes

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

New Client Intake/Assessment Form

Client's Name _____ Date _____

Please circle the areas below that led client to seek counseling today:

Relationship/Family Issues	Behavioral Problems	Alcohol/Substance Use	Anger/Rage
Sad or Depressed Mood	General Stress	Career/Occupational Issues	Abortion Issues
Anxiety/Worry/Fear	Divorce Issues	Eating Disorder/Weight	Excessive Crying
Excessive Sleeping	Financial Problems	Grief/Loss/Mourning	Fear of Death
Insomnia	Guilt/Shame	Legal Problems	Marriage Issues
Memory Loss	Nightmares/Phobia	Obsessive Thoughts	Panic Attacks
Parenting	Problems with Peers	Physical Health Problems	Physical Abuse
Pre-marital Counseling	Sexual Orientation	Sexual Abuse/Rape	Sexual Addiction
Step/Blended Family Issues	Problems at School	Pornography Use	Other

SAFETY Issues

1. Is client currently experiencing suicidal thoughts? Yes No
2. Does client have a desire to cause pain to self or others? Yes No
3. Is client in fear for his/her life or personal safety? Yes No
4. Has client ever had serious thoughts of suicide? Yes No
5. Has client ever attempted suicide? Yes No If Yes, When _____ How _____
6. Has someone close to client committed suicide? Yes No If yes, When _____ Relationship ____

Client Health Questionnaire

In the past 30-days, have you

1. Lost interest or pleasure in doing things; felt down, blue, depressed, or hopeless? Yes No
2. Had problems at work? How many days were you unable to work? _____ Yes No
3. Had trouble falling asleep or staying asleep; or the opposite, sleeping too much? Yes No
4. Experienced feelings of guilt and shame or feeling responsible for bad things? Yes No
5. Experienced changes in eating habits, poor appetite or overeating; weight gain or loss? Yes No
6. Felt bad about yourself; felt that you are a failure; felt that you have let people down? Yes No
7. Had difficulty concentrating on things like reading, watching television, or completing tasks? Yes No
8. Had a problem moving or speaking too slowly; or the opposite, being fidgety or restless? Yes No
9. Lost interest in sex; or the opposite, spent a great deal of time thinking about sex? Yes No
10. Experienced thoughts that you would be better off dead or of hurting yourself in some way? Yes No

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

New Client Intake/Assessment Form

Client's Name _____ Date _____

CAGE Assessment

1.	Have you had a drink or used drugs in the past 30 days?	Yes	No
2.	In the past 30 days, have you ever felt you ought to cut down on your drinking or drug use?	Yes	No
3.	In the past 30 days, have people annoyed you by criticizing your drinking or drug use?	Yes	No
4.	In the past 30 days, have you ever felt bad or guilty about your drinking or drug use?	Yes	No
5.	In the past 30 days, have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	Yes	No
6.	How many days in the past week did you have a beer, glass of wine, mixed drink, or shot of liquor? _____		
7.	On a typical day when you have had a drink, how many glasses, bottles, cans, and/or shots do you drink? _____		
8.	Have you had a problem with alcoholism or addiction in the past?	Yes	No
9.	If yes, how long have you been clean and sober? _____		
10.	Are you currently participating in a recovery program such as AA, Celebrate Recovery, etc.?	Yes	No

PATHOS Sexual Health Assessment

1.	Do you often find yourself preoccupied with sexual thoughts?	Yes	No
2.	Do you hide some of your sexual behavior from others?	Yes	No
3.	Have you ever sought help for sexual behavior you did not like?	Yes	No
4.	Has anyone been hurt emotionally because of your sexual behavior?	Yes	No
5.	Do you feel controlled by your sexual desire?	Yes	No
6.	When you have sex, do you feel depressed afterwards?	Yes	No

PATHOS Sexual Health Partner/Spouse Questionnaire

1.	Does your partner seem preoccupied with sexual thoughts and behavior?	Yes	No
2.	Does your partner hide his/her sexual behavior from you?	Yes	No
3.	Do you feel your partner needs help for sexual behavior?	Yes	No
4.	Have you been hurt emotionally because of your partner's sexual behavior?	Yes	No
5.	Does your partner seem to be controlled by his/her sexual desire?	Yes	No
6.	Has your partner accused you of being "crazy" or "jealous" when you question his/her sexual behavior?	Yes	No

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

Policies and Procedures

We hope your experiences at Alpha Omega Delta prove to be meaningful and rewarding. The information presented below is to help clarify our approach and procedures regarding the counselor/client relationship.

Time of Appointments: Appointments may be scheduled for 50, 75, or 100-minute sessions. Sessions will begin and end at the scheduled time. If the counselor causes a late start, the session will last the full length of the scheduled session or be prorated. If client arrives late for the appointment, the session will end at the regularly scheduled time and the charge will be for the full amount. You will be billed for your regular fee if you cancel with less than a 24-hour notice. Missed or frequent rescheduling may result in termination of counseling. In this case, the counselor will provide a list of other mental health professionals.

Payment Information: ***Full Payment is Expected at Time of Service***

Payment is expected at the beginning of each session and may be made by cash or credit/debit card. Sessions will be billed at the rate of $100 for the first 50-minutes. Longer sessions will be billed in 25-minute increments.
Please initial that you understand and agree that you will be responsible for payment. _____

Consultation: At times it may be necessary to briefly contact your counselor by telephone or email for which there is no charge; however, when this exceeds 10-minutes the charge is $20 per 10-minute period. Payment for consultation is expected at the next scheduled session.

Out-of-Office Service: Any out of office services will be billed at $20 per 10-minute period including drive time from the Alpha Omega Delta office to the out-of-office location.

Reports: At times it may be necessary for your counselor to prepare a diagnostic summary, at your written request, for a collaborating third party. This request must be made on an official Alpha Omega Delta Authorization to Disclose Confidential Records form. Disclosure is limited to dates of service, service code, billing information, and a diagnostic summary. Report preparation services will be billed at $20 per 10-minute period.

Legal Proceedings: You agree not to subpoena the counselor for deposition or as a witness, in any legal or administrative proceedings before, during, or after the counseling process. To the extent that you may have the right to call the counselor, that right is hereby waived. You agree not to subpoena or demand the production of any psychotherapy notes, records, summaries, work products, or the like of the counselor in any legal or administrative proceedings. You agree to make no request that any notes or records prepared by the counselor, before, during, or after the counseling process, be used or admitted as evidence in any legal proceedings. To the extent that you may have the right to demand these documents, that right is hereby waived. In the event that such subpoena is executed, you agree to pay any and all legal fees incurred by the counselor to enforce this agreement, quash any subpoena, or otherwise seek necessary legal representation. You further agree to pay counselors fee billed at $20 per 10-minute period for all time counselor devotes to enforcing this agreement.
Please initial that you understand and agree to this policy regarding Legal Proceedings and Reports . _____

Discrimination: Alpha Omega Delta will not tolerate any discriminatory procedures, as defined below, and immediate action will be taken if such an act occurs (Administration Code 8 CSR 60-3.010)(1): “Discrimination in public accommodations because of race, color religion, national origin, ancestry, sex, or handicap is prohibited by law in Missouri.”

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

Consent to Treat: By signing below you agree to participate in counseling services from Alpha Omega Delta and hereby consent to receive treatment and/or evaluation as deemed necessary by your assigned counselor. You understand that all counselors hold at least a Master's degree and are Licensed Professional Counselors, Provisionally Licensed Professional Counselors, or Counselors in Training. You agree, release, and authorize professional consultation between the counselors associated with Alpha Omega Delta.

Confidentiality Policy: As a client you have the right to confidentiality. Counselors are bound by ethical codes for their profession and under HIPPAA Privacy Practices. Information discussed in the therapy setting is considered and held sacred and will not be shared without your written consent except under the following conditions:

- Client threatens harm to self or others.
- Client is a minor and reports suspected child abuse/neglect.
- Counselor receives information which causes the counselor to believe the client is in a state of mind where the client poses a threat of harm to self or another person.
- Client gives information that causes the counselor to suspect a threat of harm defined as child abuse/neglect, elder abuse/neglect, or dependent adult abuse/neglect.

You acknowledge that thoughts of self-harm sometimes occur during the course of counseling. This document serves as a contract between you and your counselor, affirming that you are currently free from intention to harm yourself or others and commit to contact counselor or emergency medical services should these thoughts arise or intensify. Client further agrees to cooperate with recommended treatment including but not limited to inpatient care if indicated.

Counselor reserves the right to request that you make an appointment with your personal physician before continuing counseling. It is important to make sure that physical health difficulties are properly addressed and do not impede the counseling process.

Client hereby acknowledges and agrees to accept an electronic Notice of Privacy Practice, located on our website at alphaomegadelta.net with an effective date of January 1, 2014. You can ask for a paper copy of this notice at any time.

Having read and understood the above, you hereby consent to treatment, agree to these limits of confidentiality and disclosure, payment arrangements, and policies concerning legal proceedings.

Name (Please Print) _____

Signature: _____ Date: _____

Name (Please Print) _____
(If under 18 years of age, parent/guardian must sign)

Signature: _____ Date: _____
(If under 18 years of age, parent/guardian must sign)

Counselor: _____ Date: _____

Alpha Omega Delta
Professional Counseling
2200 E Sunshine ~ Springfield, MO 65804 ~ (417)881-2444

Alpha Omega Delta's "No Secrets" Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in ***Family Therapy or Couple's Therapy***, that the counselors at Alpha Omega Delta Professional Counseling consider the couple or family as a treatment unit and considers that unit to be the identified patient. During the course of work with a couple or a family, your counselor may see a smaller part of the treatment unit (e.g., an individual or siblings) for one or more sessions. These sessions should be seen as a part of the work with the treatment unit, unless otherwise indicated. If you are involved in one or more such sessions, please understand that generally these sessions are confidential in the sense that confidential information will not be released to a third party unless required by law or with your express written authorization; however, it may be necessary to share information learned in a session with only a portion of the treatment unit being present with the entire treatment unit. Your counselor will use his/her best judgment as to whether, when, and to what extent to make disclosures to the treatment unit. If appropriate, your counselor will first give the individual the opportunity to make the disclosure. If you feel it necessary to talk about private matters, it may be necessary to consult with another counselor who can provide individual therapy. This "no secrets" policy is intended to allow the counselor to treat the family unit by preventing, to whatever extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If counselor is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their therapy, the counselor may be placed in a situation resulting in termination of treatment. This policy is intended to prevent the need for such a termination.

Reports: At times it may be necessary for your counselor to prepare a diagnostic summary, at your written request, for a collaborating third party. This request must be made on an official Alpha Omega Delta Authorization to Disclose Confidential Records form and must be signed by all adult members of the treatment unit. Disclosure is limited to dates of service, service code, billing information, and a diagnostic summary. Report preparation services will be billed at $20 per 10-minute period.

Legal Proceedings: You agree not to subpoena the counselor for deposition or as a witness, in any legal or administrative proceedings before, during, or after the counseling process. To the extent that you may have the right to call the counselor, that right is hereby waived. You agree not to subpoena or demand the production of any psychotherapy notes, records, summaries, work products, or the like of the counselor in any legal or administrative proceedings. You agree to make no request that any notes or records prepared by the counselor, before, during, or after the counseling process, be used or admitted as evidence in any legal proceedings. To the extent that you may have the right to demand these documents, that right is hereby waived. In the event that such subpoena is executed, you agree to pay any and all legal fees incurred by the counselor to enforce this agreement, quash any subpoena, or otherwise seek necessary legal representation. You further agree to pay counselors fee billed at $20 per 10-minute period for all time counselor devotes to enforcing this agreement.

We acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with the counselor, and that we enter couple/family therapy in agreement with this policy.

Name (please print)	Signature
Name (please print)	Signature
Counselor's Signature	Date