Brenda S. Butterfield, EdD, MSW, LMHC
Our New Experience (ONE), LLC
425-324-7336

Previous Client Intake and Assessment Form

Date:_____

Name:_____Gender _____

Mailing
Address:_____

City:_____ State:_____ Zip:_____

INSURANCE/PRIVATE PAY

Do you have Insurance? _____ (Y or N) Insured through an employer? _____(Y or N)

Insurance Mental Health Coverage: Yes_____ No_____ Co Pay Amount: _____ (Cash or Credit)

Policy Holder's Legal Name (Last, First, MI): _____

Client's relationship to policyholder: _____

Address (if different than yours) _____

Subscriber's ID Number (Include Alpha Prefix if appropriate) _____

Policy Holder's Date of Birth: _____Insurance: _____

ID #:_____ Group Number: _____

If no insurance, how do you intend to pay? Cash or Credit Card (circle one)
Sliding Fee Scale Rate: _____/52-55 Minutes

I authorize Dr. Brenda Butterfield, Our New Experience (O.N.E.), LLC to bill and release information to my carrier listed and is paid directly by insurance carries for services billed. I acknowledge that I am responsible for all charges not paid by my insurance company, including co-pays, deductibles, failed and late cancelled appointments.

If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Client Signature:_____ Date _____

Emergency contact:_____ Relationship:_____ Phone _____

Health Problems (please list major illnesses or conditions within the last year)

Name of your psychiatrist/ARNP _____ Date last seen _____

Diagnosis made by Psychiatrist _____

Would you like me to coordinate your Mental Health Care with your Psychiatrist? _____ (Y or N)

Telephone Number _____

Current Psychiatric Medications you are taking:

Medication:_____Dose_____

Medication:_____Dose_____

Have you ever felt suicidal? _____ (Y or N) If Yes, when and under what circumstances? _____

Have you ever attempted suicide: _____ (Y or N) If Yes, when and under what circumstances?

Do you feel suicidal at this time? _____ (Y or N)

Have you ever been violent toward others? _____ (Y or N) If Yes, when and under what circumstances?

Do you have violent thoughts toward someone? _____ (Y or N) If Yes, toward whom do you feel this way?

Do you feel like hurting someone at this time? _____ (Y or N)

Which drugs (not medications prescribed for you) have you used in the last year?

REASONS FOR COUNSELING

What specific event(s) or experience(s) have led you to seek counseling at this time?

Describe how well you are taking care of yourself these days:

Please rate the amount of concern your problem is causing in each of the following areas by placing a "Check Mark" in the box/column that most closely describes it.

Symptom	No Concern	Some Concern	Moderate Concern	Serious	Very Serious	Not Applicable
Ability to sleep						
Ability to work						
Ability to concentrate						
Appetite						
Relationships						
Depression						
Thoughts of suicide						
Thoughts of homicide						
Physical health						
Memory loss						
Alcohol/Drug concerns						
Anxiety						
Irritable						
Feeling hopeless						
Feeling overwhelmed						
Trouble breathing						
Ringing in ears						

What do you hope to gain from counseling at this time?

How will you know counseling is helping?

Thank you for filling out this form.