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Our New Experience (ONE), LLC
425-324-7336

Client Intake and Assessment Form

Date:_____

Birth date:_____ Email Address:_____

Name:_____Gender _____

Mailing
Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Messages OK? _____ (Y or N)

Email Address: _____ OK to Email You? _____ (Y or N)

Employer/School:_____ Occupation:_____

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: _____/50 Min

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, Parent or Guardian Signature:_____ Date _____

REFERRAL and EMERGENCY CONTACT INFORMATION

Referred By:_____ May I thank them?_____

Emergency contact:_____ Relationship:_____ Phone _____

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HEALTH HISTORY AND and MEDICATION INFORMATION

Date of last physical _____ Physician's Name _____

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

Medical History Pertinent to our work together: (surgeries, major illnesses, chronic disease, conditions):_____

Primary Care Physician:_____ Phone # _____

Would you like me to coordinate your Mental Health Care with your MD? _____ (Y or N)
(If "Yes", you will need to sign a *Release of Information* form giving me permission to release your private health information to your primary care physician.)

Have you seen a Psychiatrist? _____ Date last seen _____

Psychiatrist's Name _____ Telephone Number _____

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

(If "Yes", you will need to sign a *Release of Information* form giving me permission to release your private health information to your primary care physician.)
Have you had previous counseling? _____ (Y or N) Approximately when? _____

If yes, please briefly describe your previous experience in counseling:

Please list previous mental health diagnoses made by other clinicians:

Diagnosis _____ When _____

Diagnosis _____ When _____

Current Medications you are taking

Medication:_____Diagnosis_____

Medication:_____Diagnosis_____

Medication:_____Diagnosis_____

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)

CHEMICAL USE

Have you ever felt the need to cut down on your drinking? • No • Yes

Have you ever felt annoyed by criticism of your drinking? • No • Yes

Have you ever felt guilty about your drinking? • No • Yes

Have you ever taken a morning "eye-opener", or “Wake and Bake”? • No • Yes

How much beer, wine, or hard liquor do you consume each week, on the average?_____

How much tobacco do you smoke or chew each week? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

_____

LIVING ARRANGEMENT

Relationship Status: Single Cohabit Married Separated Divorces Widowed

I live with:_____ Relationship:_____

I live with:_____ Relationship:_____

I live with:_____ Relationship:_____

I live with:_____ Relationship:_____

REASONS FOR COUNSELING

What specific event(s) or experience(s) have led you to seek counseling now?

In the space below, tell me what you think is important for me to know about you.

What are your most favorite activities, interests and hobbies?

What do you do to relax and take care of yourself?

Describe how well you take care of yourself:

What was the role of religion or spirituality in your upbringing and in your life currently?

Clients who request to work with me often do so because they want a therapist who has a Body, Mind and Spirit perspective (*whole person perspective*). Why is it you have chosen to see me specifically?

What are your thoughts about mental health counseling from a whole person perspective?

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						

Describe how receptive you are to new treatment modalities including meditation, relaxation techniques, guided imagery, journaling, etc.?

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.