PRECIOUS HEARTS FOUNDATION

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INTAKE FORM – ANGER MANAGEMENT

All information is kept confidential and will not be released without your written permission.

TODAY'S DATE:_____

COURT/CASE INFORMATION
(***if you have not been charged yet fill out to the best of your ability)***

Name
Case # / Charges
Number of Court-Ordered Sessions
Attorney's Name / Phone
Is there an existing Restraining Order In Place? ☐ Yes ☐ No Against Who?
Are you currently court-ordered to participate in any other programs? ☐ Yes ☐No If Yes, which programs do you participate in?
Was this incident Alcohol/Drug related? ☐ Yes ☐ No If yes, how many alcohol/drug -related incidents have you had in the past?

DOB:___/____/_____ Gender: ☐Female ☐Male ☐Other_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widow ☐ Co-Habituating ☐Separated

How many children do you have? _____

Were they affected by your actions? ☐ Yes ☐ No

If yes,
explain:_____
_____
_____

Occupation/Name of Employer:_____

Employer Phone Number:_____

Dependents in your home?: ☐ Yes…..How Many_____ ☐ No

Emergency Contact/Relationship :_____

Phone:_____

Symptoms: Please circle any symptoms that apply:

Aggression/Anger Outbursts	Anxiety	Chest Pains/Tightness
Eating Disorder	Fatigue	Worrying
Irritability	Memory Problems	Worthlessness
Suicidal Thought	Weight Loss/Gain	Restlessness
Alcohol/Drug Abuse	Avoidance of people	Depression
Elevated Mood	Fears	Gambling
Loneliness	Mood Swings	Panic Attacks
Trembling	Withdrawal	Racing Thoughts
Difficulty Thinking	Helplessness	Sleeping Disorder
Difficulty Concentrating	Dizziness	Impulsivity
Headaches	Sexual Addiction	Stress
Other	Sexual Difficulties	Hopelessness

Current Stressors : Please Circle all that apply

Marital/Relationship conflict	Health problems	Conflict with parents
Poor Peer relations	Physical	Recent move
Legal problems	Conflict with children	Housing problems
Victim of abuse	Job loss or change	Conflict with family
Separation/Divorce	Recent death	Financial Problems
Problems at work	Emotional	Other (Please write below)

Have you been in any type of counseling in the past? ☐ Yes ☐ No (If yes, please explain below)

_____

_____

Anything else you want the therapist to know? (Please write below)

_____

_____

Are you seeing a psychiatrist : ☐ Yes ☐ No (If yes, please fill out information below)

Name and Phone Number_____

Last time seen by Psychiatrist:_____

Primary care Physician:_____ Phone Number:_____

Date of last visit:_____ Date of last physical:_____

Current Medication:_____ Dosage:_____

Current Medication:_____ Dosage:_____

CLIENT ATTESTATION REGARDING THE INFORMATION PROVIDED ON THIS INTAKE FORM

I do hereby attest and verify that the information I have provided above is true to the best of my knowledge. If, at some later time I recall information not on this form that I feel would be relevant to my treatment, I will update my therapist.

Date:_____

Print Name:_____

Sign Name:_____

NO CALL / NO SHOW / LATE CANCELLATION POLICY

This policy has been established in order to provide the highest level of clinical services to all of our clients. It has been proven that consistent attendance to one's treatment provides the greatest opportunity for success. By providing proper notice of a cancellation, we may be able to accommodate other clients with your appointment slot.

Additionally, I schedule time aside to ensure that you receive my undivided attention and the expectation is that you will arrive at least 5 minutes early for your session.

Please make arrangements for childcare
I DO NOT ALLOW CHILDREN ON ANY CALLS

A late arrival of 15 minutes of more does not allow time for a proper session and will be identified as a missed appointment. If you need to cancel or reschedule, I require 24 hours' notice. Cancellations within 24-hours of appointment will be considered a late cancellation and will be assessed a cancellation fee of $55.00 will be applied.

• A Client will be allowed to continue with their therapy after two no-show/late cancellations, provided an acceptable explanation is supplied to the Therapist.

• After three (3) no shows/late cancellations, the Client will be discharged from treatment, as the client will have demonstrated a lack of commitment to the therapeutic process and would therefore not be an appropriate candidate for treatment. Notice will be sent to both the court and your attorney explaining the reason for discharge and all future appointments will be removed from the schedule.

• While we do understand that emergencies arise and that it may not be possible to give such a notice, exceptions to the No-Show/Late Cancellation Policy will be discretionary and an ultimate decision made by the treating therapist.

I have discussed, acknowledge and fully understand the No Call/No Show Late Cancellation Policy.

Date:_____

Print Name:_____

Sign Name:_____

FINANCIAL RESPONSIBILITY:

Payments to be rendered the same day as service

Policy for Collections:
In the event that a client fails to render payment for a session(s), or fails to pay any No Show fees, Precious Hearts Foundation will notify the client twice within a 30-day period to allow them time to pay the past-due amount. After 30 days has lapsed without payment, the matter will be turned over to a collection agency for collection of the debt. A notice will also be sent to the County Superior Court and Probation Department.

I have read, understand and agree to the terms and conditions set forth above and my obligation as set forth in the Financial Responsibility section.

Date:_____

Name (PRINT)_____

Name (SIGN)_____

CONFIDENTIALITY DISCLOSURE

During therapy we will explore different aspects of functioning including difficult emotional stories from different stages of your life. Sometimes these issues will include things you don't want others to know. As a general rule, I keep all information you share with me confidential, however, by law I am required to disclose information whether or not I have your permission. I have listed some of these situations below:

- **You tell me you plan to cause serious harm or death to yourself**, and I believe you have the intent and ability to carry out this threat in the near future. I must take steps to inform a family member, parent/guardian, or specialized team of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

- **You tell me you plan to cause serious harm or death to someone else** who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform the authorities and I must inform the person who you intend to harm.

- **You tell me a child is being abused physically, sexually, emotionally** or that you have been abused in the past. In this situation, I am required by law to report the abuse to Child Protective Services.

- **You tell me an elderly person is being abused, physically, sexually, financially, or emotionally,** at which point I will have to report to Adult Protective Services.

- **Subpoena**. You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to do so through subpoena. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

I have discussed these issues with my therapist, and I understand that confidentiality can be broken when there is serious threat of self-harm, harm to others, or the safety of children and elderly people, or if subpoenaed by the court.

Date:_____

Print Name:_____

Sign Name:_____

TERMINATION OF TREATMENT

Termination of services can occur for different reasons and may be terminated when any of the following occurs:

- Completion of services is achieved
- I feel that you are in need of a higher level of treatment and your issues fall out of the scope of my practice. In this case, appropriate referrals will be provided
- Excessive missed appointments. A report will be sent to the Court, Probation and your attorney.
- Inappropriate behavior and/or comments during treatment – A report will immediately be sent to the Court, Probation and your attorney.

DISCLOSURE REGARDING TREATMENT OUTCOMES

CONSENT FOR TREATMENT

I have been informed and understand that while there are significant benefits to participating in therapy, as it may have an impactful and positive effect in mitigating symptoms related to each individual's issues, it is in no way a guarantee of a favorable outcome regarding the therapy process or your court case. As such, I do hereby consent to treatment.

I have read, discussed and understand the "Termination of Treatment", and "Disclosure Regarding Treatment Outcomes / Consent for Treatment"

Date:_____

Print Name:_____

Sign Name:_____

This page for Therapist's use only

Therapist's Attestation

I have reviewed this intake form and asked the client if they understood and agreed to the terms and conditions of treatment as set forth above. Additionally, I addressed and provided clarification regarding any concerns and/or questions the client had related to this form, prior to the commencement of treatment.

Date:_____

_____
Elva Chase, BCCC
Certification: #17888

Notes: ☐ None

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_____

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