Lynne Coon, Licensed Professional Counselor (LPC)
1020 SW Taylor, Suite 448 | Portland, OR 97205 | 503-243-2283

Confidential Intake

1. Identifying Information

Your Name ____ Date __________________

Gender: F____ M ___Age: ____ Birth Date ____

Current Address: ____

City, State, Zip ____

Phone(s): ___________________ (H) _____________________(W) _______________________ (C)

Which number is the best to reach you? Home Work Cell

Is it okay to leave a message identifying myself at the above number? yes / no

Email Address:______________________________Employed? Full time Part time Student No

Employer __________________________________ Position __________________________________

How did you find me? Psychology Today | Network Therapy | Portland Therapy Center | Find-A-Therapist | internet search | other ____

Referred by (friend / doctor/ organization / counselor) ____

Would you like to … Receive infrequent email updates (2-3 times per year at most)? yes / no

Others living at home (whether family or not) /and immediate family living outside the home:

Name	**Age**	**Relationship to client**	**In home/** (circle one) **Outside home**
			In / Out
			In / Out
			In / Out

If you need more room please write on the back of this page.

Partnership Status:

Check one

	single/no significant relationship
	significant relationship/engaged (length of relationship:)
	married/life partner (length of relationship:)
	separated
	divorced
	widowed
	other

Partner Information

Employer / Position: __________________________________Education Level:___________________

About your parent(s):

Check one

	biological
	adoptive
	married
	living together
	separated (date:)
	divorced (date:)
	father (deceased date:)
	mother (deceased date:)

Occupation & Education of Parent(s):

Mother ____

Father ____

Number of Brothers/Sisters ____

Please describe the reason you are seeking counseling:

____

____

____

What, if anything, have you done about the above so far?

____

____

____

Have you worked with a counselor before? yes_____ no_____

Name of Counselor ____

Date(s) of therapy: ____

(please describe, including what was helpful and what wasn't, if relevant)__________________

____

____

Please list the goal(s) you would most like to achieve in therapy:

____

____

____

____

____

Make an "X" to the left of the description for any of the following you've been experiencing:

	Depressed Mood		Feelings of Hopelessness
	Extreme Sadness		Tearful/Crying Spells
	Trouble Concentrating		Memory Problems
	Sleeping Problems (describe below)		Lack of Energy / Fatigue
	Change in Eating Habits		Weight or Appetite Changes (describe below)
	Problems Getting Along with Family		Problems Getting Along with Friends
	Don't Enjoy Usual Activities		Extreme Happiness (describe below)
	Feeling Stressed		Irritability
	Social Life is Not Satisfactory		Self Esteem Problems (describe below)
	Isolation/Withdrawal		Perfectionist
	Relationship Problems		Feelings of Guilt
	Feel Fearful		Panic Attacks (describe below)
	Physical Complaints of Pain		Tense/Uptight
	Anger Outbursts		Acting Violently
	Financial Problems		Legal Problems
	Concerns About My Children		Thoughts of Harming Self
	Thoughts of Harming Others		Feel Like a Failure
	Fear I'm Going Crazy		Concerns About Sexual Matters
	Career Indecision/Concern		Concerns About Physical/Emotional Abuse
	Difficulties Trusting Others		Difficulty Expressing Myself
	Concerned About my Ethnic/Racial Background/Identity		Concerned About my Sexual/Gender Identity/ Orientation

Any other symptoms not listed above OR describe more detail about anything circled: ______________

____

____

Have you been prescribed any <u>psychiatric</u> medications? yes_____ (please describe below) no _____

Medication Name	**Purpose**	**Dates Taken**

4. Substance Use History:

Do you use tobacco, in any form? Currently_________ Past ___________ No ___________

Do you use alcohol? Currently_________ Past ___________ No ___________

If currently, indicate the frequency of use:

(1) __Less than once a week (2)__ More than once a week (3) other, please specify: ____________

Do you use recreational drugs? Currently_________ Past ___________ No ___________

If currently, indicate the frequency of use:

(1) __Less than once a week (2)__ More than once a week (3) other, please specify: ____________

5. Medical Information

Are you taking any prescription or <u>over-the-counter</u> medications? yes __ (please describe below) **no___**

____

____

____

____

Please list any major medical problems that you have had such as chronic illness, serious illness, surgeries, injuries, or trauma:

____

____

____

____

Do you have any allergies to anything? yes _____ (please describe below) no _____

____

____

____

____

Is there anything else you'd like me to know?

____

____

____

Counseling sessions are confidential with the following exceptions:

1. You give me written permission to share information with specific others.
2. A court orders your information to be released.
3. Your situation involves suspected child, adult, or elder abuse or neglect.
4. Your situation involves potential danger to self, others and/or property.
5. Consultation or supervision.

I give Lynne Coon permission to provide counseling services to me. I have been informed of the limits of confidentiality.

Signature: ____ Date __________________

Medical Information continued on next page

Who is your primary care doctor (PCP)? ____

Address and/or clinic name:____

City: ______________________________________Phone:_____________________________________

May I contact your PCP to coordinate care? If yes, please sign and date at the bottom of the page:

CONSENT TO RELEASE Confidential Information

I, hereby authorize **Lynne Coon, L.P.C.** to exchange information about:

____

(Name) (Date of Birth)

with____

(Agency and/or Individual)

Extent of information to be disclosed:

____

Purpose of this disclosure of information:___________ Coordination of care ________________________

____

____

I may revoke this release, in writing at any time, except to the extent of action that has already been taken.

Date, event, or condition upon which this release expires:

____

It is understood that the information specified above will not be released to any third party agency or individual without my knowledge and consent. State laws (ORS 192.500, ORS 179.505) and federal law (HIPAA, Pub protect the confidentiality of this information L. No. 104 – 191, 1996).

____

Signature Date

BILLING AUTHORIZATION

(for clients using insurance or EAP benefits)

I, ____, hereby authorize Lynne Coon, L.P.C., to bill my insurance company or employee assistance program.

____ Date: ____________________

Client's (Guardian's) Signature

NOTE: If you're not the primary insured, please be sure to include the full name of the person who is and their relationship to you. In order to bill insurance I also need their home address and date of birth.

Primary Insurance Information:

Your Relationship to Insured:____

Name: ____

Address: ____

City, State, Zip____

Birth Date: ______________________________ SSN:___________________________________

Phone(s): __________________ (H) ____________________(W) ______________________ (C)

Employer Name: ____

Individual ID Number: ____

Policy or Group Number:____

Insurance Plan Name or Program Name:____

NOTE: If your partner has insurance or both your parents have insurance, I'll need information on the secondary insurer as well. The insurance company chooses how much they'll pay and often already knows if there's a secondary insurer.

Secondary Insurance Information:

Your Relationship to Insured:____

Name: ____

Address: ____

City, State, Zip____

Birth Date: ______________________________ SSN:___________________________________

Phone(s): __________________ (H) ____________________(W) ______________________ (C)

Employer Name: ____

Individual ID Number: ____

Policy or Group Number:____

Insurance Plan Name or Program Name:____