OSHITA COUNSELING

NORMA L. OSHITA-DUNN, LMFT
LICENSED MARRIAGE & FAMILY THERAPIST • MFC #103325
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INTAKE FORM – ADULT - IEHP

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

TODAYS DATE:_____

First Name:_____ Last Name:_____

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

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Co-habituating

Occupation & Name of Employer:_____

Phone Number:_____

How did you hear about us?
_____

Dependents in your home?: ☐Yes How Many?_____ ☐ No

Emergency Contact/Relationship :_____ Phone:_____

Reason(s) for Seeking Therapy - Include a description of your current issues_____
_____

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)_____
_____

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:_____

Past Medication:_____Dosage:_____

Past Medication:_____Dosage:_____

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

_____

_____

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:_____

Client Release /Disclosure of Mental Health Information

Completion of this document authorizes the use and/or disclosure of your treatment/Mental Health information.

Client Name:_____

Client Address:_____

Date of Birth:_____

I hereby authorize:	***To Release Information to:***
Oshita Counseling Norma L. Oshita-Dunn 78401, HWY 111, Suite V La Quinta, Ca. 92253 Phone: 760-972-6882 Fax: 760-459-1031 Email: NormaOshita@gmail.com	**Inland Empire Health Plan (IEHP)** 10801 6th St #120 Rancho Cucamonga, CA 917308 800-751-5909

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 IN THE WAITING AREA

A late arrival of 15 minutes of more does not allow time for a proper session and will be identified as a missed appointment - your insurance carried will be notified. If you need to cancel or reschedule I require 24 hours' notice. Notifications with less than 24-hours of notice will be considered a late cancellation.

• 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 IEHP 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:_____

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 certain 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 am mandated 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. The services are voluntary, and you can cancel at any time, unless mandated to attend by the court. Additionally, services may be terminated when any of the following occurs:

- Completion of services is achieved
- Client decides services are no longer necessary and/ or they advise me that they are in need of a higher level of treatment or that they no longer wish to receive treatment
- I feel that our current approach is out of scope for my practice. In this case, appropriate referrals will be provided
- Excessive missed appointments
- Inappropriate behavior and/or comments during treatment

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. 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:_____

_____
Norma L. Oshita-Dunn, M.S., LMFT
State License: MFC#103325

Notes: ☐ None

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