The Center for COUNSELING RECOVERY & GROWTH

INTAKE FORM

2780 Skypark Drive, Suite 205
Torrance, California 90505
310.803.9484

Client Name: _____ Today's Date: _____

Address: _____
street city state zip

Home Phone: _____ Birthdate: _____ Age: _____

Cell Phone: _____ Social Security #: _____

Work Phone: _____ Marital Status:
Single ☐ Married ☐ Separated ☐ Divorced ☐

Email: _____

Occupation: _____ Employer/School: _____
name city

In Case of Emergency, Notify: _____ Phone: _____

How did you find me? _____

Would you like to receive helpful tips and news from me occasionally? Email: ☐ U.S. Mail: ☐ None: ☐

Spouse Name (Parents, if minor): _____ Age: _____

Occupation: _____ Employer: _____

List family members and others in your home:

Name	Age/Birthdate	Relationship	Occupation

Family Physician: _____ Phone: _____

Medication	Dosage (Times Daily)	Purpose

Over →

Briefly describe your reasons for seeking therapy/counseling: _____

_____

Have you ever participated in therapy or counseling of any kind? YES ☐ NO ☐

If yes, where and when? _____

Have you ever attempted suicide? YES ☐ NO ☐ If yes, when: _____

Do you presently have suicidal thoughts? YES ☐ NO ☐

Please **CIRCLE** any of the following that apply to you at this time:

Nervousness	Depression	Fears	Rape Trauma
Shyness	Sexual Orientation	Suicidal Thoughts	Weight Gain
Hearing Voices	Divorce	Finances	Anxiety
Drug Problem	Alcohol Problem	Sexual Abuse/Molestation	Sense of Failure
Anger	Self Control	Weight Loss	Grief
Abuse as Child	Battering	Unhappiness	Fatigue
Sexual Problems	Stress	Work	Increased Appetite
Sleep Impairment	Headaches	Tiredness	Decreased Appetite
Relaxation	Memory Impairment	Making Decisions	Ambition
Legal Matters	Insomnia	Assertive Skills	Marriage
Mood Swings	Inferiority Feelings	Concentration	Nightmares
Loneliness	Career Choices	Health Problems	Temper
Education	Parenting Skills	Stomach Problems	Aging Parents
Children	Social Isolation	Uncontrollable Thoughts	Death of Loved One
Bowel Troubles	Relationships	Panic Attacks	Loss Experience

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CLIENT CONSENT FORM

Client Name (Printed):

Initials	***Form to be completed by client*** *(Or parent/guardian if client under the age of 18)*
	FINANCIAL TERMS: Psychotherapy sessions are typically 50 minutes in length and are billed at a rate of $160.00 per session. *I prefer to be paid at the time services are rendered*. If this is a hardship for you I will be open to discuss your particular situation. As a courtesy, I may decide to bill your health plan/insurance. But it is your responsibility to verify your coverage and policy limits. You (client or guardian) will be responsible for any applicable deductibles, co-payments, or uncovered services. If applicable, co-payments are to be paid at the time services are rendered. If you are without health plan/insurance coverage, payment arrangements can be made at the conclusion of your first appointment.
	CANCELLATIONS / MISSED APPOINTMENTS: When we decide to work together it means that I am setting aside time exclusively to meet with you. I will not accept phone calls during sessions, unless of course there is an emergency. I will also do everything in my ability to be emotionally and intellectually present. In return I expect you to make therapy a priority too. This means that you will attempt to be as honest with me as you can, you will arrive promptly for our sessions, you will not drink alcohol or take any illegal drugs prior to our sessions, and that you will provide me with at least a 24-hour cancellation notice. *If an appointment is missed or cancelled with less than 24 hours notice, you agree to pay me my full fee for the missed appointment.* There are times when I can fill your appointment if someone is on my waiting list. So it is important to let me know as soon as possible if you cannot keep an appointment. Frequent cancellations may result in the termination of your treatment; your compliance in keeping appointments and active participation in the treatment process are vital.
	APPEALS AND GRIEVANCES: You have the right to request reconsideration in the case that outpatient care (number of visits) is not authorized by your insurance company. This is called an appeal. You can request and appeal through me or directly through your Health Plan. You risk nothing in exercising this right. You also have the right to submit a complaint directly to me at any time that you have a complaint about any aspect of your care. If you are not satisfied with the response you receive, you may submit the complaint to your Health Plan directly or by contacting the Department of Consumer Affairs - (800) 633-2322 or by writing to the Medical Board of California, Allied Health Complaints, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.
	EMERGENCIES: If you are in imminent danger call 911 or your nearest police department or emergency room. I provide 24 hours, 365 days a year telephonic emergency service. If you are experiencing a psychiatric crisis, you may contact me by calling (310) 530-7750 x14. I will be paged when a message is left at that number.

Please continue on reverse side

	TREATMENT PHILOSOPHY: The purpose of psychotherapy is to help you cope more effectively with your life. Hopefully your situation will improve during the course of therapy, but that doesn't mean the benefit comes immediately and without pain. Many times your situation will get worse before it gets better. Sometimes it is necessary to deconstruct unhealthy patterns in your life and in your relationships before you can reconstruct healthier patterns. My particular style of therapy is direct and "no nonsense." While I have proper education, training, and experience, it doesn't mean my style will benefit you. Penicillin can save one person's life and kill the next if he or she is allergic. I will be responsible for providing you with the most powerful and helpful therapeutic experience during our sessions, but ultimately you are responsible for your life. If you don't think I am helping you, then please let me know as soon as possible. We will discuss what is missing and see if I can meet your needs, if not, I will gladly try to help you find a therapist who may be a better fit.
	CONFIDENTIALITY: All information between therapist and client is held strictly confidential unless: 1. You authorize release of information with your signature (or parent/guardian) 2. You present a physical danger to self 3. You present a danger to others 4. Child or elder abuse is suspected In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.
	CONSENT FOR TREATMENT: "I further authorize and request that Kevin Bergen, MFT carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable.
	RELEASE OF INFORMATION TO THE HEALTH PLAN: I acknowledge the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan and I have received a copy of Confidentiality of Personal and Health Information.
	RELEASE OF INFORMATION TO THE PRIMARY CARE PHYSICIAN: "I authorize the release of information to my Primary Care Physician (name)_____for purposes related to my health care."

I understand and agree to the above:

Client/Guardian's Signature	Date

Client/Guardian's Signature	Date