LISA WOLPER LCSW
Licensed Psychotherapist

825 College Ave.
Santa Rosa, CA 95404
(707) 524-8864
Lic. # LCS12890
lisawolper.com

Intake Information and History

Place an * by any questions you're not comfortable addressing in writing and we'll discuss them in your initial session.

Date: _____ Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____

Occupation: _____ Employer: _____

Ethnicity/heritage: _____ Religious/spiritual affiliation: _____

With whom do you live? _____

Relationship/Marital Status: _____ Name of partner: _____

Do you have children? If yes, please list names and ages: _____

What is your primary reason/concern for seeking counseling? _____

_____

_____

_____

What are the biggest challenges you are facing in your life? _____

_____

_____

_____

Treatment and Medical History

Are you currently receiving, or have you previously received, services from a counselor/mental health professional (i.e., psychiatrist, therapist)? YES or NO

If yes, please list provider name and dates of treatment:

Provider _____

Dates of Treatment _____

Provider. _____

Dates of Treatment _____

Have you ever been hospitalized for psychiatric or drug/alcohol treatment? YES or NO

If yes, please describe the circumstances, including length of hospitalization and dates:_____

_____

_____

_____

Have you ever attempted suicide? YES or NO If yes, how many times and when?_____

_____

_____

_____

Are you having suicidal thoughts now? YES or NO If yes, please describe:_____

_____

_____

_____

Please list any medications you are currently taking:_____

_____

Please list any herbal supplements or other non-prescribed meds you are currently taking:_____

_____

What is your current use of alcohol and/or drugs? _____

_____

Are you currently receiving treatment for a medical condition? If yes, please describe:_____

_____

Please describe your state of health and any physical problems you may have at this time:_____

_____

_____

Psychosocial History

Are you aware of any history of mental illness, alcoholism, or drug abuse in your family? YES or NO

If yes, please describe: _____

_____

_____

_____

Any history of physical, emotional, or sexual abuse? YES or NO

If yes, please describe: _____

_____

_____

_____

Please add anything else you would like me to know about you at this time:_____

_____

_____

_____

_____

_____

_____

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Client Information and Agreement

These are my business policies. If you have any questions or concerns about them, please feel free to discuss them with me today.

CONFIDENTIALITY: All conversations in therapy are held in confidence. No information about you is released without your written consent. However, there are exceptions clearly mandated under state law. I am required by law to break confidentiality in cases involving abuse or neglect or a child under the age of 18; elder abuse; or threats of serious bodily harm to oneself or others.

SESSION LENGTH: Sessions are scheduled for 50 minutes. If you need to arrive late, the session will still need to end at the scheduled time. If I am running late, you will receive your full 50 minute session.

TELEPHONE CALLS: There is no charge for occasional, brief phone calls of 5 or 10 minutes in length. If you need to talk longer, we will schedule an additional session.

PAYMENT: Fees are due at the beginning of each session unless other arrangements have been made. To maximize session time, please have check written before coming to the appointment.

CANCELLATION: When we schedule an appointment, I reserve the time specifically for our session. If you need to cancel an appointment, I require that you call at least 24 hours in advance of your appointment time or you will be charged for the missed session.

EMERGENCIES: Please call my office as soon as possible in the case of an emergency. I check for messages frequently during the day, and will return your call as soon as I am able. Unfortunately, I cannot always reach you or be available for emergencies. If you have an

emergency and cannot reach me, please call the Sonoma County Mental Health Crisis Line at 707-576-8181.

I have received a copy of these policies and agree to abide by them.

_____ _____

Client Signature/ Date Therapist Signature/ Date

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Authorization to Release Confidential Information

I, (name of patient)_____ hereby authorize Lisa Wolper, LCSW, to release confidential information obtained during the course of my treatment to_____

This Authorization permits the release of the following information:

___ Any and All Information Necessary

___ Diagnosis ___Treatment Plan ___ Prognosis

___ Progress to Date ___ Clinical Test Results ___ Dates of Treatment

___ Patient Records ___ Summary of Treatment

___ Other _____

I authorize the release of the information described above for the following purposes(s):_____

I understand that I have a right to receive a copy of the authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____ (expiration date)

By: _____Date_____