



Southwest Family Physicians

— YOUR FAMILY IS OUR FAMILY —

11900 SW Greenburg Rd
Tigard, OR 97223

Phone: (503) 620-5556

Fax: (503) 624-0118

Adult Intake Form - Scarlet Graham, LPC

Please fill out this form and bring it to your first session.

Client's Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Age: _____ Legal sex: ☐ Male ☐ Female

Partner's Name (if being seen as a couple): _____

Referred by: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Other (specify): _____

Home phone: (____) _____ Cell phone: (____) _____ Work phone: (____) _____

May I leave a message? ☐ Yes ☐ No

Others living in the home:

Name	Date of birth	Relationship to client

Education: Client: _____ Partner: _____

Occupation: Client: _____ Partner: _____

Client's Employer: _____

SSN: Client: _____ Partner (optional): _____

Emergency Contact: _____ Phone: (____) _____

Presenting Problems

Describe the problems that brought you here today:

Staff use only

Client Name: _____

File number: _____

Check any of the symptoms that you are experiencing:

- | | | |
|--|--|---|
| ☐ Depression | ☐ Problems getting along with friends/family | ☐ Muscle tension |
| ☐ Extreme sadness | ☐ Lack of enjoyment in usual activities | ☐ Problems with anger |
| ☐ Feeling hopeless | ☐ Self-esteem problems | ☐ Acting violently |
| ☐ Feeling tearful | ☐ Easily irritated | ☐ Feeling tired or having little energy |
| ☐ Problems sleeping | ☐ Perfectionism | ☐ Thoughts of hurting yourself or others |
| ☐ Memory problems | ☐ Feeling guilty | ☐ Feelings of extreme happiness |
| ☐ Lack of energy | ☐ Obsessions or compulsions | ☐ Poor appetite or overeating |
| ☐ Change in eating habits | ☐ Feeling nervous | ☐ Thoughts of killing yourself or others |
| ☐ Weight changes | ☐ Sudden feelings of panic | ☐ Feeling fearful |
| ☐ Change in sexual interest or function | ☐ Moving or speaking so slowly that other people could have noticed | |
| ☐ Trouble concentrating | ☐ Physical complaints of pain | |
| ☐ Trouble performing your job | | |

If you checked off any symptoms, how difficult have these symptoms made it for you at work, home, or with other people?

Circle one: Not difficult at all Somewhat difficult Very difficult Extremely difficult

Family History

Relationship	Name	Age	If living: city & state of residence If deceased: year of death
Father			
Mother			
Step-parent			
Step-parent			
Sibling			
Sibling			
Sibling			
Sibling			

Partner History

Name of previous partner	Date of marriage/ move in	Date of divorce/ separation

Staff use only

Client Name: _____

File number: _____

Children: Please list all of your children, both living and deceased.

Name	Date of birth or age	Gender

Did your parents divorce or separate? ☐ Yes ☐ No If yes, how old were you? _____

With whom did you live with growing up? _____

Have you been physically abused? ☐ Yes ☐ No ☐ Don't remember

Have you been sexually abused? ☐ Yes ☐ No ☐ Don't remember

Did you witness abuse between parents? ☐ Yes ☐ No ☐ Don't remember

Did you witness abuse between parents & children? ☐ Yes ☐ No ☐ Don't remember

Have you ever considered or attempted suicide? ☐ Yes ☐ No

If so, when? _____

Have other members of your family attempted or committed suicide? ☐ Yes ☐ No

If so, who & when? _____

Have you had any previous counseling experience or psychiatric hospitalization? ☐ Yes ☐ No

If so, when & with whom? _____

Was it helpful? ☐ Yes ☐ No Please explain: _____

Medical Information:

Have you seen a doctor within the past year? ☐ Yes ☐ No If yes, please fill out the table.

Doctor	Reason

Staff use only

Client Name: _____

File number: _____

What medicines (prescribed or over-the-counter), herbs, or vitamins do you take?

Medicine, Herb, Vitamin	Reason	Prescribing doctor

Do you have allergies? ☐ Yes ☐ No If yes, describe allergy problems: _____

Do you use tobacco? ☐ Yes ☐ No If yes, what kind and how much daily? _____

Do you drink caffeine (coffee or tea)? ☐ Yes ☐ No If yes, how many cups daily? _____

How much alcohol do you drink (average drinks per week)? **0** **1-5** **6-10** **11-20** **over 20**

What other drugs do you use? _____ How often? _____

Has your use of alcohol or other drugs caused problems or been a concern to you/others? ☐ Yes ☐ No

Have you sought treatment for problems with alcohol or other drugs? ☐ Yes ☐ No

Staff use only

Client Name: _____

File number: _____



Professional Disclosure Statement

*Scarlet Graham, MA, Clinical Mental Health Counseling
LPC - Licensed Professional Counselor*

Philosophy and Approach to Counseling:

I believe that people hold the keys to a healthy emotional balance within themselves. By joining with the client in seeking emotional, physical, and spiritual health, an empowering environment develops. As I recognize and honor client strengths and resources, clients develop a means through which to address their issues and facilitate change. My goal as a counselor is to help clients identify personal needs, understand conflicts, discover new options, and make informed choices. My approach to counseling is integrative with the utilization of a number of techniques to explore client concerns including; cognitive-behavioral philosophy (exploring one's thoughts and beliefs), that incorporates client-centered techniques (allowing the client to set the pace and topics of each session) and assist in developing coping skills and treatment goals together with you. My goal as a counselor is to help clients identify personal needs, understand conflicts, discover new options, and make informed choices.

Formal Education and Training:

I hold a Master of Arts degree in Clinical Mental Health Counseling from George Fox University and I see children, adults and their families for comprehensive therapy. Major areas of course work include psychopathology, human and child development, psychological theory, and cognitive and behavioral therapy. One of my specialties is working with adults and children on the high end of the Autism Spectrum-formerly called Asperger's. One of my passions is sandplay therapy, which is very effective for children and a recognized type of therapeutic modality for adults. In addition to my academic studies, I have additional training in dialectical behavioral, emotion focused, intersubjectivity, asperger's, sandplay and art therapy, early childhood development and reactive attachment disorder in children.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

Scope of Practice:

I provide counseling services to clients of all gender identities and sexual orientations. Please note that surgical-readiness evaluations and letters for gender-affirming surgeries are outside my scope of practice, as these assessments require specialized training and clinical competencies that I do not hold. This is a matter of scope and clinical competence rather than a limitation on the care I provide.

Fees:

My fee is \$195 for the first 60 minute session and \$175 per 60 minute session afterwards.

Confidentiality and Client Bill of Rights:

As a client of an Oregon Licensee, you have the following rights:

1. To expect that a licensee has met the minimal qualification of training and experience required by the state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);

4. To report complaints to the board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: **(a)** Reporting suspected child abuse; **(b)** Reporting imminent danger to client or others; **(c)** Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; **(d)** Providing information concerning licensee case consultation or supervision; and **(e)** defending claims brought by client against licensee.
7. To be free from being the object of discrimination on the basis of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Information may also be disclosed if a client signs a written authorization.

Electronic transmission and caller identification-by phone, cell phone, email, FAX, or internet, increases risk for breach of confidentiality. Is it okay to email or leave messages on your cell phone?

Please indicate: ☐ Yes ☐ No **Initial:** _____

Voluntary Participation:

Therapy is understood to be a choice made by the client. Outcomes cannot be guaranteed; although it is our hope, it will be successful. Some clients need only a few sessions to achieve their goals, while others may require several months or years of counseling. Alternative options include other therapists, books, support groups, self-help resources, and other modes of treatment. Medical treatment may also be an option. A client has the right to terminate treatment at any time, however, it is understood that terminating prematurely may result in the return or worsening of symptoms.

Emergencies:

In the event of an emergency, you may contact the crisis line in Clackamas at (503) 655-8585 or Washington County at (503) 291-9111, call 911, or report to the nearest emergency room facilities.

You may contact the Board of Licensed Professional Counselors and Therapists at:

Address: 3218 Pringle Rd SE, #120, Salem, OR 97302-6312

Telephone: (503) 378-5499

Email: lpct.board@state.or.us

Website: www.oregon.gov/OBLPCT

Consent to Treatment: Your signature below indicates consent to treatment under the conditions listed above.

Client first & last name

Date of birth

Client Signature (legal guardian if under 15 years of age)

Date

Therapist Signature

Date



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Dear Patient,

In addition to the clinic policies outlined in Southwest Family Physicians' new patient paperwork, please review the points below regarding scheduling, appointments and fees with me, Scarlet Graham, LPC.

1. Rates are billed per your insurance coverage. If I have a binding contract with your insurance company, your co-pay serves as your responsibility for payment to our office. This payment is due at check-in prior to any visit. If I do not have a binding contract with your insurance company, I am considered an "out of network" provider. Based on your specific insurance plan, your fiscal responsibility for each visit may be more than that of an "in network" provider. Please see the billing office for questions regarding rates per sessions and contact your insurance directly for all other inquiries.
2. All appointments (including all first evaluations) that are missed, canceled or rescheduled less than 24 hours from the scheduled date and time are considered a late cancellation/reschedule and you will be billed \$75. Insurance will not cover your missed appointments, so it is important that you cancel and reschedule appointments at least 24 hours prior to your appointment to be considerate of others who may want to schedule in your place.
3. Three or more "no shows" or late cancellations/reschedules per one 6 month period will result in a discharge from our behavioral health program. If you miss your first appointment without any communication or any attempt to reschedule, you will not be allowed to schedule another session.
4. Scheduling can be directed through the front desk by calling (503) 620-5556. No in person appointments can be scheduled with me as I do not work in the office. All appointments must be telemedicine. If you have not received a link for a scheduled appointment, please call in advance for it and not at the time of your appointment.
5. On a final note, if you have not been seen for an appointment in over 6 months, your file will be closed. A new initial assessment will be required to re-establish care with me.

Thank you for remembering these guidelines. If you have any questions, please ask and I will be happy to discuss them with you further.

Sincerely,

Scarlet Graham , LPC

I acknowledge that I have received and reviewed this document and am aware of its contents.

Patient's First and Last Name (Printed)

Date of birth

Signature

Relation to patient if not the patient

Date



Name: _____

Date of birth: _____ Today's date: _____

Patient Health Questionnaire — 9 (PHQ-9)

Over the last **two weeks**, how often have you been bothered by any of the following problems?

	0 Not at all	1 Several days	2 More than half the days	3 Nearly every day
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed or hopeless.				
3. Trouble falling or staying asleep				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or thinking you are a failure				
7. Difficulty concentrating or feeling like you can't stay focused				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless.				
9. Thoughts of hurting yourself or thinking you would be better off dead.				

If you checked off **any** problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Staff Only

PHQ-9 Score _____



Generalized Anxiety Disorder 7-item (GAD-7) Scale

Over the last **two weeks**, how often have you been bothered by any of the following problems?

	<u>0</u> Not at all	<u>1</u> Several days	<u>2</u> More than half the days	<u>3</u> Nearly every day
1. Feeling nervous, anxious, or on the edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Becoming so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Staff only GAD-7 Score _____
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The Mood Disorder Questionnaire

Instructions: Please answer each question to the best of your ability

	Yes	No
1. Has there ever been a period of time when you were not your usual self and ...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
... you were so irritable that you shouted at people or started fights or arguments?		
... you felt much more self-confident than usual?		
... you got much less sleep than usual and found you didn't really miss it?		
... you were much more talkative or spoke much faster than usual?		
... thoughts raced through your head or you couldn't slow your mind down?		
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
... you had much more energy than usual?		
... you were much more active or did many more things than usual?		
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
... you were much more interested in sex than usual?		
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
... spending money got you or your family in trouble?		
2. If you checked 'Yes' to more than one of the above, have several of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

Staff only
 Mood Score _____



Bipolar Spectrum Diagnostic Scale (BSDS)

1. Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and/or energy levels shift drastically from time to time.	
These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high.	
During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed and get extra sleep; and little or no motivation to do things they need to do.	
They often put on weight during these periods.	
During their low phases, these individuals often feel "blue", sad all the time, or depressed.	
Sometimes, during these low phases, they feel hopeless or even suicidal.	
Their ability to function at work or socially is impaired.	
Typically, these low phases last for a few weeks, but sometimes they last only a few days.	
Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed.	
They may then notice a marked shift or "switch" in the way they feel.	
Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do.	
Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper".	
Some individuals, during these high periods, may feel irritable, "on edge", or aggressive.	
Some individuals, during these high periods, take on too many activities at once.	
During these high periods, some individuals may spend money in ways that cause them trouble.	
They may be more talkative, outgoing, or sexual during these periods.	
Sometimes, their behaviors during these high periods seems strange or annoying to others.	
Sometimes, these individuals get into difficulty with co-worker or the police during these high periods.	
Sometimes, they increase their alcohol or non-prescription drug use during these high periods.	

2. Now that you have read this passage, please check one of the following four boxes:

- | | |
|--|--|
| ☐ This story fits me very well, or almost perfectly | ☐ This story fits me fairly well |
| ☐ This story fits me to some degree, but not in most respects | ☐ This story does not really describe me at all |

3. Now please go back and put a check after each sentence that definitely describes you.

Staff Only BSDS Score _____
