

The Self Center

Robert & Joyce Simpson, Family Counseling Professional Corporation

18671 Allegheny Drive • North Tustin, CA 92705 • (714) 997-9600 • Fax: (714) 997-9607

Email: RDSimpson@aol.com

General Intake Sheet

Name: _____ Date of Birth: __/__/__ Today's Date: __/__/__
Age: _____ Social Security No.: _____ Driver's Lic. No.: _____
Address: _____ City: _____ State & Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
E-mail Address: _____ Education: _____ Religion: _____
Occupation: _____ Employer: _____ Length of Employment: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

Family: (list names and ages of family members living with you) _____

Marital Status: _____ Spouse's (or significant other's) name: _____
Length of Relationship: _____

Have you ever had counseling or psychotherapy? Yes ___ No ___ When: _____
Name and location of former psychotherapist: _____ City & State: _____
Physician: (name) _____ Address: _____ City: _____
State: _____ Zip: _____ phone: (____) _____ fax: (____) _____
List current health problems: _____

List all medications, both prescribed and not prescribed, that you are taking: _____

Do you drink alcohol or take illegal drugs? Yes ___ No ___ Type: _____ Frequency: _____

Authorization: I understand that I am personally responsible for payment for all professional services whether or not covered by my insurance. I also understand that I am responsible for paying for any session not cancelled at least 24 hours in advance. Furthermore, I authorize The Self Center to request and release information to professionals that are involved in my treatment.

Signature: (client or guardian) _____ Dated: _____

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Exceptions to the Rules of Confidentiality between a Psychotherapist and Client

I understand that all communication between myself and my psychotherapist is privileged communication and that confidentiality shall be maintained in all circumstances except the following:

If I am, or some one I know is, or has been a victim of child or elder abuse. This is to include, as of the year 2000, emotional abuse inflicted on a minor.

If I am a danger to myself.

If I am a danger to others or property..

If I am gravely disabled.

If I have sought or obtained the services of my psychotherapist to enable or aid anyone to commit or plan to commit a crime or tort or to escape detection or apprehension after the commission of a crime or tort.

If I communicate information to my therapist in a setting outside her/his office when one or more other people are present.

If I do not pay the fees for treatment, I waive the privilege of confidentiality, specifically regarding my status as a patient/client. I also understand that the psychotherapist can pursue the collection of such fees through legal processes.

If I am in couples, family and/or a group setting where others would be privy to this information

If I waive confidentiality by signing a Release of Information form.

If I waive confidentiality by signing the Insurance Claim form.

My signature below verifies that I have read and understood the above exceptions to the rules of confidentiality in my relationship with my psychotherapist/counselor.

Patient/client signature: _____ Dated: __/__/__

Parent or Guardian's signature: _____ Dated: __/__/__

