Amanda Holden Counseling
1110 SE Alder St. #301
Portland, OR 97214

www.amandaholdencounseling.com
amanda@amandaholdencounseling.com
503.839.2230

INTAKE QUESTIONNAIRE

GENERAL

Today's Date: _____

Name _____ Date of Birth _____

Address _____ City _____State _____ Zip _____

Phone - Day: _____ Evening: _____ Cell: _____

Is it okay to leave message on any of the above numbers? _____

How do you describe your race and/or ethnicity? _____

What is your gender? _____

What are your gender pronouns (they, he, she, ze, etc.)? _____

What is your current relationship status?
Partnered _____ Separated _____ Divorced _____ Married _____ Widowed _____

How long have you been together with your significant other(s)? _____

Are you in a monogamous, mostly monogamous, polyam, or open relationship?_____

Concerning sexual/romantic orientation, how do you self-identify? _____

How did you find my practice or who referred you to counseling with me? _____

What cultural beliefs and/or traditions are especially important to you that you would like me to know about?_____
_____

Are you currently attending school or a training program? _____ If yes, please describe: _____
_____
_____

Please check which one describes your current situation best:

_____ Employed _____ Unemployed: looking for work _____ Unemployed: in school/training
_____ Unemployed: not looking/not in school/training _____ Retired

_____ Employed part-time/part-time stay-at-home parent _____ Full-time stay-at-home parent

If applicable, what is your profession and/or area of study or professional training? _____

MENTAL HEALTH

Have you ever received a mental health diagnosis? _____ If yes, please provide details (diagnosis, provider, date) _____
_____

Have you been in individual counseling before? □ Yes □ No
If so, give a brief summary of concerns you addressed.
_____
_____
_____

Has a physician prescribed mental health/psychiatric medications for you to be taking currently? _____

Current mental health medications: _____
_____

Have you ever been hospitalized for mental health reasons? _____

Have you ever considered suicide? When was the last time you thought about suicide? _____
_____

Have you ever experienced abuse, neglect, or trauma?_____
In the tough times, what are things you turn to to feel better? _____
_____

MEDICAL AND SUBSTANCE USE

Who is your primary care doctor? _____ Doctor/prescriber's phone # _____

Emergency contact: _____ Phone #: _____ Relationship to you: _____

Are you receiving any other health care (nutrition, chiropractic, massage, naturopathic)? _____

If so, where and from whom? _____
Do you have current medical concerns of which you believe I should be aware? If so, please explain:
_____

Current medications/supplements	Reason	Prescriber (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use tobacco products? _ If yes, how much and how often? _____

How many drinks of alcohol do you consume each week? _____

Have you used recreational drugs (including marijuana, misuse of prescription pills) in the past year? _____

If yes, please specify which drug(s) and how often _____
_____

Have you ever received treatment for substance abuse or dependency? _____ If yes, please describe: _____

_____

_____

FAMILY HISTORY

Please complete the following information about your family:

Name: Please circle those adults who raised you	Age	How would you describe your relationship with this person when you were a young child? Now?	Is this person living or deceased?	Current or past substance abuse problems?	Current or past mental health problems?
Parent					
Parent					
Parent					
Step-Parent					
Step-Parent					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Grandparent					
Grandparent					
Grandparent					

When you were a child and feeling upset or hurt, what would you do? How would your parents or caregivers respond to you when you were feeling upset or hurt? _____

When a parent or caregiver was feeling upset with you, what would they do? _____

In what ways do you believe your early childhood experiences with your parents/guardians have affected you in relationship to your partner?_____

Are there specific events in your childhood you believe had a profound impact on the person you are today?_____

Tell me about the relationship your parents or guardians had with one another. How would you describe what it was like when you were a child?_____

Did you experience the death of a loved one during childhood or adolescence? If so, how did you respond? Are there specific events in your childhood you believe had a profound impact on the person you are today? _____

Tell me about anger in your family. Who felt it and how did they show it? How did you know someone was upset in your family-of-origin? _____

Do you have any children? _____ If yes, please provide the following information about the children in your family:

Name: Please indicate if biological or step-child	Age	How would you describe this child?	Is your child living or deceased?	Substance abuse problems?	Mental health problems?
Child					
Child					
Child					
Child					
Child					
Child					

Have you ever had a miscarriage, stillbirth, or abortion you'd like to me to know about? _____ If yes, what would you like me to know about the result on you now and your current relationships? _____

RELATIONSHIP

Name of partner:_____
Partner's date of birth:_____

1. Have you and your partner engaged in prior couples' counseling? □ Yes □ No

If yes, when: _____ Where: _____
With whom: _____ Length of time in counseling: _____
Concerns addressed: _____
_____

2. What was the outcome? Please check one and provide brief summary.
□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse
_____
_____

3. Rank order the top three goals that you have in your relationship with your partner (1 being the most important):

1. _____
2. _____
3. _____

4. What have you already done to accomplish these goals? _____
_____

5. As you think about the primary reason that brings you here, how would you rate your overall level of concern at this point in time?

□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concerns

6. What might get in the way of therapy? _____
_____

7. On a scale of 1 to 10, what is your level of commitment to this relationship (1 = not at all, 10 = extremely). ____

8. Have either of you threatened to separate or divorce (if married) as a result of the current relationship challenges?

If yes, who? ___Me ___Partner ___Both of us

9. Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, who has withdrawn? ___Me ___Partner ___Both of us

Thank you for completing this. Please bring this with you during your first appointment and **please note you will be asked to talk about your answers in sessions**.

PROFESSIONAL DISCLOSURE STATEMENT

Amanda Holden, LPC, CADC-I
1110 SE Alder St. #301
Portland, OR 97214
503.839.2230
www.amandaholdencounseling.com

My goal for you as my client is to provide a safe, supportive environment in which you can move toward greater health and healing. I can help you make desired changes as well as move toward an improved quality of life, self-respect, self-discovery, and healthier relationships. I believe that everyone, no matter their life experiences thus far, has the capacity to do this. To assist clients, I employ tenets of therapy modalities such as Motivational Interviewing, Cognitive Behavioral Therapy, Narrative Therapy, Client-Centered Therapy and Reality Therapy. I hold a master's degree in Marriage and Family Therapy from George Fox University.

As a licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my professional counseling license, I am required to participate in annual continuing education in subjects relevant to this profession and am permitted to substitute professional supervision for part of this requirement.At my discretion, I may consult with other mental health professionals (e.g., a professional consultation group) about your concerns and therapy, including disclosing your confidential information. This helps ensure I am providing you the best care possible. These mental health professionals are bound by the same ethical and legal standards of confidentiality as I am.

I have also met the necessary training and work experience requirements to be designated a Certified Alcohol and Drug Counselor (CADC-I). As a CADC-I with the Addiction Counselor Certification Board of Oregon, I abide its Code of Ethics as well.

My fee per 50-min couple's session is $190. Please inquire about sliding fee options if you cannot afford these fees.

As a client of a licensee with the OBLPCT, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be informed that, by law, your protected health information may be released only with your written consent, except where permissible or required by law.
- To be assured of privacy and confidentiality while receiving services as defined by rule and law including, but not limited to, the following exceptions:
  - When the client or those persons legally responsible for the affairs of the client give consent to the disclosure;
  - When reporting suspected child abuse or neglect, elder abuse or neglect, or abuse or neglect of those with development disabilities;
  - When the communication reveals the intent to commit a crime or harmful act;
  - Reporting imminent danger to the client or others;
  - Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
  - Providing information concerning licensee case consultation or supervision; and
  - Defending claims brought by client against licensee;
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the Oregon Board of Licensed Professional Counselors and Therapists at 3218 Pringle Road SE #120, Salem, OR 97302-6312. Telephone: (503) 378-5499. Additional information about this counselor or therapist is available on the Board's website Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT

By signing below, I acknowledge that I have read this statement and understand my rights as a client. I also understand that counseling can be difficult and challenging.

Client Name (Print)	Client Signature	Date
Amanda Holden, LPC, CADC-I	Date	

INFORMED CONSENT

It is important at the beginning of our professional therapeutic relationship you understand both the nature and limitations of the relationship. The therapy relationship is a professional and confidential relationship. What is revealed in the setting is generally protected by professional and ethical standards, to the extent that, with a few important exceptions, all material you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which I am ethically or legally required to disclose information. I am required to disclose information in the following circumstances:

- If there is a reasonable belief child abuse has occurred.
- If there is a reasonable belief elder abuse has occurred.
- If there is a reasonable belief abuse of an adult with developmental disabilities has occurred.
- If you make a threat to seriously harm a third party.
- If you pose a serious risk to yourself or others.

In therapy, I'll endeavor to provide you with the best care I can. To facilitate this, please advise me of your physical and emotional conditions to the best of your ability. Therapy can be exciting and helpful and often it can feel hard or stressful. Please let me know if you are struggling or need help and I will do what I can to put you at ease. It's important to know sometimes feeling worse is a precursor to feeling better.

Please do not use email communication for therapeutic issues, emergencies and crises. Email communication with me is only for the purposes of providing general information about counseling or scheduling. If your email contains other information, questions or concerns, I will print out the email and bring it to our next session together for discussion. Also, I only respond to emails and phone calls on Mondays, Wednesdays, Fridays, Saturdays, and Sundays excluding major US holidays. Please do not email in an emergency. If you are in immediate danger, please call 911 or the crisis line at 503.988.4888.

As a therapist, I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to: Untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, your needs are outside my scope of competence, or you are not making adequate progress in therapy. You have the right to terminate therapy at your discretion. Upon either person's decision to terminate therapy, I will generally recommend that you participate in at least one termination session. I will also attempt to ensure a smooth transition to another therapist by offering referrals.

In order to maintain an accurate picture of active clients to ensure available appointments as well as availability for new folks, if you have not had an appointment with me for a period of 6 weeks, I will no longer consider you a current client. At that time, I will send you a formal email notification of your file closure and new status as a former client. Although you are always welcome to reach out in the future, I am not able to guarantee the ability to restart appointments for former clients. Certainly, I'm always happy to hear from former clients and would be happy to begin therapy again together if our schedules allow.

As this is a business for me, it is important that you let me know with *at least 48 hours'* notice if you cannot make an appointment or need to reschedule. **If you fail to cancel a scheduled appointment with fewer than 48 hours notice, I cannot use this time for another client and *you will be billed the full fee* for your missed appointment.**

Name as listed on card: _____
Card #: _____Expiration date: _____
3 digit CCV code: _____Zip code:_____

I have read the above information and understand what it says. I have been given a Personal Disclosure Statement and an Informed Consent Form.
To the extent I have questions, I have asked them of my therapist before signing this consent.

Date: _____Client Signature: _____Date of Birth:_____

COUPLES' THERAPY INFORMED CONSENT

It is important to understand as you enter couples' therapy that my focus for treatment is on the preservation and enhancement of the relationship.

With this in mind, when a couple begins therapy to address their relationship with one another, the couple is treated as the client unit. In order for me to preserve my neutral position in the therapeutic relationship, please note the following.

- All communication that is shared with me, regardless of format or means, will be open to both in the relationship and shared as I deem clinically appropriate.
- In order for me to provide effective couples' therapy, I will not keep secrets between members of the client unit at my discretion.
- I will not provide individual therapy for either parties involved in couples' therapy, but at times, may recommend individual sessions as a means to better meet the couples' therapy goals.

By entering couples' therapy, you understand and accept that working toward positive change in a relationship often involves experiencing difficult or painful emotions, and engaging uncomfortable and new behaviors in order to reach therapeutic goals. It is also important to understand that as one or both of you begin making changes, this will impact not only your partner, but often your friends and family dynamics. These changes can have both positive and negative effects on your relationships with others. By signing below, you agree to evaluate potential effects of such changes before making them.

I have read the above information and understand what it says. To the extent that I have any questions, I have asked them of my therapist before signing this consent.

Client Signature Date

Client Signature Date

Amanda Holden, LPC, CADC-I Date

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI) BY NON-SECURE MEANS

I, _____ AUTHORIZE: Amanda Holden
(name of client) (name of clinician)
_____ 1110 SE Alder St. #301.
(client's email address) (street address)
Portland, OR. 97214

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:
O Information related to the scheduling of meetings or other appointments
O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information related to resources and referrals
O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:
O Unsecured email.

TERMINATION
O This authorization will terminate _____ days after the date listed below.
OR
O This authorization will terminate when the following event occurs: counseling with Amanda terminates.
I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____
Client Name

_____
Client Signature Date

_____
Amanda Holden, LPC, CADC-I Date

ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically using a payment card through Square.

Please Be Aware of the Following:
I have a duty to uphold your confidentiality and thus wish to make sure that your use of the above payment service is done as securely and privately as possible.

After using Square to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include my business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. I am unable to control this in many cases, and may not be able to control to what email address or phone number your receipt is sent.

Before using Square to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card may appear on your credit card statement as being made to Amanda Holden Counseling. Please consider who might have access to your statements before making payments by credit card.

I have read this disclosure and have had the opportunity to ask questions regarding this information. I consent to the use of electronic payment and automatic receipt.

Client Name

Client Signature Date

Amanda Holden, LPC, CADC-I Date

Telehealth Services Informed Consent

Amanda Holden, LPC, CADC-I
1110 SE Alder St. #301, Portland, OR, 97214
www.amandaholdencounseling.com
amanda@amandaholdencounseling.com

What is Telehealth?

Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health care.

Services delivered via telehealth rely on a number of electronic, often Internet-based, technology tools. These tools can include video conferencing software, email, text messaging, virtual environments, specialized mobile health ("mHealth") apps, and others.

I will be providing telehealth services using the following tools:

Hushmail for secure emailing
Doxy.me for video sessions

- You will need access to Internet service and technological tools needed to use the above-listed tools in order to engage in telehealth work with me.
- If you have any questions or concerns about the above tools, please address them directly with me so we can discuss their risks, benefits, and specific application to our work together.

Benefits and Risks of Telehealth

Receiving services via telehealth allows you to:

Receive services at times or in places where the service may not otherwise be available.
Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.

Receive services when you are unable to travel to my office. The unique characteristics of telehealth media may also help some people make improved progress on health goals that may not have been otherwise achievable without telehealth.

Receiving services via telehealth has the following risks:
Telehealth services can be impacted by technical failures, may introduce risks to your privacy, and may reduce my ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

Internet connections and cloud services could cease working or become too unstable to use
Cloud-based service personnel, IT assistants, and malicious actors (“hackers”) may have the ability to access your private information that is transmitted or stored in the process of telehealth-based service delivery.
Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.

Interruptions may disrupt services at important moments, and I may be unable to reach you quickly or using the most effective tools. I may also be unable to help you in person.

There may be additional benefits and risks to telehealth services that arise from the lack of in-person contact or presence, the distance between you and I at the time of service, and the technological tools used to deliver services. I will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Assessing Telehealth’s Fit For You

Although it is well validated by research, service delivery via telehealth is not a good fit for every person. I will continuously assess if working via telehealth is appropriate for you and your treatment goals. If it is not appropriate, we will discuss what other options are available to you at the time. result in termination of services. Bringing your concerns to me is often a part of the process.

You also have a right to stop receiving services by telehealth at any time without prejudice. If I am also providing services in-person at that time and you are reasonably able to access my in-person services, you will not be prevented from accessing those services if you choose to stop using telehealth.

Your Telehealth Environment

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with me during the session.

Our Communication Plan

We will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises. In addition to those plans, I have the following policies regarding communications:

The best way to contact me between sessions is to email me at amanda@amandaholdencounseling.com.
I will respond to your email messages on certain days of the week, as outlined in my email auto-responder. As I occasionally change the days of the week I see clients and, therefore, the days on which I respond to emails, this auto-responder will have the most up-to-date information.

I may coordinate care with one or more of your other providers, with your signed release. I will use reasonable care to ensure that those communications are secure and that they safeguard your privacy.

Our Safety and Emergency Plan

As a recipient of telehealth-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider.

I will require you to designate an emergency contact. You will need to provide permission for me to communicate with this person about your care during emergencies. I will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. It is important that you engage with me in the creation of these plans and that you follow them when you need to.

Your Security and Privacy

Except where otherwise noted, I will use software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your health care services are not lost or damaged.

As with all things in telehealth, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information.

Recordings

Please do not record video or audio sessions without my explicit consent. Making recordings can quickly and easily compromise your privacy, and should be done so with great care. I will not record video or audio sessions.

Please talk to me if you find the telehealth media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telehealth medium seems to be causing problems in receiving services.

I have read the Telehealth Services Informed Consent and have had the opportunity to ask questions regarding this information. I consent to the use of telehealth services.

In the event that I am unable to provide a "wet" signature, I will provide my digital or typed signature and I AGREE TO BE BOUND BY MY SIGNATURE BELOW.

_____

Client's Signature Date

_____

Amanda Holden, LPC, CADC-I Date

Tech Recovery & Client Safety Plan

Your emergency contact (required):

Name:	
Relationship:	
Phone #:	
Contact address:	

You give your provider permission to contact your emergency contact regarding your health care in an emergency: _____ (client(s) initials)

Technological Emergencies:

If we experience a technical failure during a session or other interaction, **I will always attempt to reconnect with you**, even if it seemed we were about to finish our interaction.
Our backup communication method is:

Method:	After attempting and failing to reconnect via video conferencing, I will call you at the number(s) you provided.
Provider's email address and phone number:	amanda@amandaholdencounseling.com 503-839-2230
Client's/clients' phone number(s) and email address(es):	
Plan:	If I am unable to connect with you via phone, I will send you a secure email.

Scene Safety Plan

Sometimes there may be other people who attempt to intrude on our session, or there may be other reasons why the space you are in is not psychologically safe for our work.
To help your provider know when your space is unsafe, we may do the following scene safety check at the beginning of each session:

Scene safety check method:	Client(s) will be asked to pick up their computer/camera and pan around the room.

Health and Safety Emergencies

If you are in a mental health crisis, you will call this number for help:	911 **OR** National Suicide Hotline: 1(800) 273-8255 **OR** Mult. County Crisis Line (503) 988.4888
If you have a medical or safety emergency, you will call 911.	

Which hospital will you go to when a medical issue arises and you are at home?

Main hospital name:	
Main hospital phone #:	
Main hospital address:	

If there is a second hospital you may go to, please list it here:

Secondary hospital name:	
Secondary hospital phone #:	
Secondary hospital address:	

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION VIA PHONE CONVERSATION BY POTENTIALLY NON-SECURE MEANS

I, _____ AUTHORIZE: Amanda Holden
(name of "Client") (name of "Clinician")

_____ 1110 SE Alder St. #301, PDX, OR
("Client's" preferred phone number)

503.839.2230
(phone number)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION VIA PHONE SESSIONS AND/OR FOLLOW-UP CALLS BETWEEN "CLIENT" AND "CLINICIAN" REGARDING MY HEALTH CARE TREATMENT (Please check):

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment

O Completed forms, including forms that may contain sensitive, confidential information

O Information related to resources and referrals

O Other information. Describe: Any and all Protected Health Information (PHI) that is or may be addressed, brought up, discussed, or referenced in any way during the course of a phone call or session between "Client" and "Clinician".

BY THE FOLLOWING NON-SECURE MEDIA (Please check):

O Unsecured phone.

TERMINATION (Please check):

O This authorization will terminate when the following event occurs: after counseling relationship terminates.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

In the event that I am unable to provide a "wet" signature, I will provide my digital or typed signature and I AGREE TO BE BOUND BY MY SIGNATURE BELOW.

_____ _____
Client's Signature Date

_____ _____
Amanda Holden, LPC, CADC-I Date