Amanda Holden Counseling
www.amandaholdencounseling.com
amanda@amandaholdencounseling.com
1110 SE Alder St. #301
Portland, OR
503.839.2230

INTAKE FORM

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/are you preferred spoken (and written) language(s)? _____

Are you an individual with a disability as defined by the ADA? _____

What is your gender? _____

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

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

If in a relationship, how long have you been together with your significant other? _____

Is this a monogamous, mostly monogamous or non-monogamous relationship? _____

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

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

What cultural beliefs and/or traditions are especially important to you?_____

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

PRESENTING CONCERNS, STRESS AND RESILIENCY

What do you enjoy most about your life? _____

What strengths do you possess? _____

How easy or difficult is it for you to think of and write down your strengths? _____

What brings you to counseling? _____

What do you enjoy least about your life? _____

What goals would you like to accomplish through our work in counseling together? _____

What is your level of comfort with experiencing strong emotions (grief, fear, hurt, etc.)? _____

What was happening in your life when your current concerns began? _____

What have you already tried to do to address your current concerns? _____

What might get in the way of therapy? _____

Have you ever experienced abuse, neglect, or trauma? _____

In the tough times, what are things you turn to to feel better? _____

Check the behaviors and symptoms that are currently problematic for you:

O lack of motivation	O thoughts of harming others	O feeling overwhelmed
O feeling bad about myself	O poor body image	O hopelessness
O trouble sleeping	O problems with pornography	O panic feelings/panic attacks
O social anxiety	O physical pain with no known cause	O thoughts about death
O racing thoughts	O difficulties with my spouse or partner	O hearing voices
O feeling afraid	O loneliness	O guilt/shame
O obsessive or intrusive thoughts	O gambling problems	O sexual problems
O paranoia	O work problems	O school problems
O parenting problems	O aggression toward others	O mood swings
O distractibility	O irritability	O sick often
O dizziness	O anger	O legal problems
O eating problems	O spiritual concerns	O anxiety
O fatigue	O memory problems	O suicidal attempts
O avoiding people	O suicidal thoughts	O chest pain
O heart palpitations	O depression	O withdrawing from people
O phobias	O disorganized thoughts	O worrying
O post-partum problems	O food problems	O nutrition concerns
O physically hurting self	O feeling sad	O loss of pleasure
O difficulty thinking	O difficulty concentrating	O crying
O weight loss or weight gain	O difficulty following through on tasks	O impulsivity
O feelings of worthlessness	O frequent nightmares	O alcohol or drug use
O see or hear things others don't see or hear		O difficulty trusting others
O distressing memories or images that appear suddenly		
O feel compelled to repeat behaviors over and over again even though irrational		
O counting, checking, or other repetitive behaviors		O other, please describe:

_____

MEDICAL

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: _____

Does anyone in your life bother or nag you about your use of alcohol or drugs? _____

PERSONAL AND FAMILY HISTORY

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 that you addressed.

Previous mental health medications: _____

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? _____

If yes, please provide details (reason, location, duration, outcome) _____

Have you ever been arrested, charged, or convicted of a crime? _____ If yes, please provide details, including date of offense(s) and offense result: _____

Are you currently on probation or parole, or in a disciplinary process or program with a professional licensing board, academic institution, employer or other entity? _____ If yes, please provide details:

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?_____

In what ways do you believe your early childhood experiences with your parents/guardians have affected you as an adult? _____

Other than parents, did you have any adults with whom you had a close, safe relationship?_____

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 that 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? _____
_____

SELF-CARE

Please check those that are true for you:

_____ I eat food that tastes good and helps me feel healthy, satisfied, and nourished

_____ I have healthy boundaries and say "no" when I need to

_____ I dance, swim, ride bikes, run, lift weights, play sports, walk, or engage in some kind of physical activity regularly

_____ I take time for myself each day to engage in something I enjoy and find restful and restorative

_____ I get at least 7-9 hours of restorative sleep each night and feel alert throughout the day

_____ I feel good about my body and can find many things I appreciate about it

_____ I take time to be sexual in ways I feel good about

_____ The time I spend using technology (computer, phone, etc.) and on social media feels healthy to me and does not cause me to feel stressed or anxious

_____ I engage in meditation, faith-based activities, and/or spiritual practices regularly that give me a sense of peace and serenity

_____ I often spend time with friends and family who are kind to me, supportive, and fun for me to be with

_____ I generally like who I am and can find many things about myself I proud of

_____ I regularly spend time in nature without my phone, computer, i-pad, etc.

_____ I can set appropriate limits with myself and others

_____ I have a good balance between my work and home life

PROFESSIONAL DISCLOSURE STATEMENT

Amanda Holden, LPC
110 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. I also regularly participate in consultation with professional colleagues in order to provide the most helpful, ethical counseling services possible. Please ask if you have questions about this.

My fee per 50-minute counseling session is $175. If you cannot afford this, we can discuss a sliding scale fee.
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, health care information pertaining to you may be released only with your written consent.
- 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	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 these 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 that I have any questions, I have asked them of my therapist before signing this consent.

Date: _____ Client Signature: _____ Date of Birth: _____

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

_____ AUTHORIZE: Amanda Holden

(name of client) (name of clinician)

_____ 110 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.

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 Name

_____

Client Signature Date

_____

Amanda Holden, LPC 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 Date

Telehealth Services Informed Consent

Amanda Holden, LPC
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 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 Date