DESERT VIEW CRISIS INTAKE FORM

PLEASE PRINT ALL INFORMATION AND COMPLETE FIRST TWO PAGES

CLIENT'S NAME: _____ AGE: _____ DOB: _____
FIRST LAST

HOME PHONE: _____ CELL PHONE: _____ SS#: _____ SEX: _____

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

PHYSICAL ADDRESS: _____ CITY: _____ ZIP: _____

PRIMARY LANGUAGE: _____ DISABILITY: _____

ETHNICITY_____ VETERAN? YES____ NO _____ PREGNANT? YES _____NO _____

SCHOOL ATTENDING: _____ GRADE: _____

REFERRAL SOURCE: _____

RESPONSIBLE PARTY: _____
FIRST LAST RELATIONSHIP DOB PHONE NUMBER

EMERGENCY CONTACT: _____
FIRST LAST RELATIONSHIP PHONE NUMBER

PRESENTING PROBLEM: DESCRIBE SPECIFICALLY THE PROBLEM THAT BROUGHT YOU TO OUR PROGRAM:

_____
_____
_____

PLEASE PUT A CHECK IN EACH OF THE AREAS THAT APPLY TO YOUR CURRENT INDIVIDUAL OR FAMILY SITUATION:

☐AGGRESSION, VIOLENCE
☐ALCOHOL ABUSE
☐ANGER PROBLEMS
☐ANXIETY
☐ BEHAVIORAL PROBLEMS
☐ DIVORCE OF PARENTS
☐ DEFIANCE
☐ DEPRESSION
☐ DELINQUENCE
☐ CHILD VICTIM/ DV WITNESS
☐ DRUG ABUSE
☐ EATING PROBLEMS
☐ EXCESSIVE STRESS
☐FIGHTING
☐ HYPERACTIVITY
☐IMPULSE CONTROL
☐MOOD SWINGS
☐NEGLECT
☐ MOOD SWINGS
☐ SUICIDAL THOUGHTS/ACTIONS
☐ PARENT(S) IN JAIL
☐PHYSICAL ABUSE
☐ CRIMINAL PROBLEMS
☐SCHOOL PROBLEMS
☐RUNAWAY
☐SEVERE BEHAVIORAL
☐SEXUAL ABUSE
☐SLEEP PROBLEMS
☐ OBSESSION

ADDITIONAL SERVICES REQUESTED:
☐INDIVIDUAL THERAPY
☐FAMILY THERAPY
☐PSYCHIATRIC CONSULT

PREVIOUS ASSESMENT? YES ____ NO _____
DIAGNOSIS? _____

_____ _____
SIGNATURE DATE WITNESS DATE

Updated 12/14/2018

CONSENT TO TREAT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Desert View Family Counseling. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. Probable consequences of not receiving treatment

2. **Clinical Supervision**: Your case may be staffed with the clinical director and/or other licensed therapist within the agency. This is to ensure the best possible outcome for you and your family.

CONFIDENTIALITY

Confidentiality means that Desert View Family Counseling has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your written consent. In such situations, Desert View Family Counseling is not required to inform you of these actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without a minor's consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself. I understand that I have the right to ask questions to my service provider about the above information at any time.

Patient Signature	Date
Parent/Guardian Signature (if patient is under 18)	Date
Signature of Witness	Date

Updated 12/14/2018