Laura LaPointe, M.S. LMFT

410 S. Glendora Ave, Suite 130, Glendora, CA 91741 (626) 466-7616

Dear New Client,

Thank you for choosing to come to see me for Individual, Couples, Family or Child Therapy.

(Please note: If the client is a child, please fill out the Child Intake form, also located under the *Forms Icon* on this website.)

I look forward to getting to know you and helping you accomplish your therapy goals. In order to complete my intake and assessment process with you **prior to our first session**, I need for you to fill out the following forms. **It is very important that you fill out these forms as honestly and thoroughly as you can.** If for any reason you feel uncomfortable filling out a certain question, feel free to leave it blank and we can discuss it together. If you have any questions, please write them down and bring them to your first session and I will be happy to answer your questions then.

Looking forward to meeting you.

Laura LaPointe, M.S., LMFT

LAURA LAPOINTE, LMFT

410 S. Glendora Ave, Suite 130, Glendora, CA 91740 (626) 466-7616

CONSENT FOR TREATMENT

Financial Terms:

Upon verification of health plan/insurance coverage and policy limit, we will bill your insurance carrier for you and your provider will be paid directly by the carrier. _____ You (patient or guardian) will be responsible for any applicable deductibles and co-payments. _____ If you do not have health insurance at the time services are rendered, you are responsible for payment. _____ Co-payments are required to be paid at the time services are rendered. __

Cancelled and Missed Appointments:

A scheduled appointment means that time is reserved only for you. If you miss or cancel an appointment with less than 24 hours' notice, you will be charged $70.00 for your appointment. Fees are due before your next appointment will be scheduled. Frequent cancellations or no-shows will result in termination of treatment. Your compliance in keeping appointments and active participation in the treatment process are vital. If a pattern of missed sessions occurs, you will not be able to retain an ongoing treatment slot as there is a waiting list for mental health services from this office.

Emergencies:

If you are in imminent danger, call 911, your nearest police department or emergency room. Your provider's policy regarding emotional crisis and their availability should be discussed during the first appointment.

Confidentiality:

All information between you and your therapist is held strictly confidential unless:

1. You authorize the release of information with your signature (or parent/guardian)
2. You present a physical danger to self.
3. You present a danger to others.
4. Child, dependent adult or elder abuse is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that preventive measures can be taken.

Consent of Treatment:

I authorize Laura LaPointe, LMFT, to carry out psychological examinations, therapy and diagnostic procedures as deemed advisable during the course of my care as a patient.

Release of Information to Health Plan:

I authorize the release of information for claims, certificates, case management, quality improvement and other purposes related to the benefits of my Health Plan.

I have read, understand and agree to all the terms listed above:

_____ _____

Patient or Parent/Guardian of Patient Signature Date

LAURA LAPOINTE, LMFT

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REGISTRATION FORM

Patient's Last Name First Middle Initial

Marital Status: Single Married Divorced Separated Widowed

Is this your legal name? Yes No

If not, what is your legal name?

Date of Birth Age

Sex: Male Female

Social Security No.

Cell Phone No.

Is it ok to leave personal and confidential messages? Yes No

Street Address City State Zip Code

Occupation Employer Employer's Phone No.

Referred By: Family Friend Doctor Insurance Hospital Other:

Name:

Do you have other family members who are seen here? Yes No

INSURANCE INFORMATION

PLEASE MAKE SURE THE OFFICE MANAGER HAS A COPY OF YOUR INSURANCE CARD

Person Responsible for Payment | Date of Birth | Relationship to Patient | Phone No.

Is the patient covered by insurance? Yes No

Insurance Company | Identification No. | Group No.

Insurance Company | Identification No. | Group No.

Emergency Contact | Relationship to Patient | Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Laura LaPointe, LMFT or my insurance to release any information required to process my claims.

Patient or Parent/Guardian of Patient Signature

Date

NEW CLIENT INFORMATION

Full Name _____ DOB ___/___/___ Age _____

Preferred Phone ( ) ____-____ ☐Cell ☐Home ☐Work ☐Other _____

Email _____ ☐Cell ☐Home ☐Work ☐Email
Preferred Communication Method

Okay to leave a message on my ☐Cell ☐Home ☐Work ☐Other _____

Residential Address _____ City _____ Zip _____

May I send mail to this address? ☐ Yes ☐ No

May I use email to send messages? ☐ Yes ☐ No

May I send you texts? ☐ Yes ☐ No

Employer _____ Type of Work _____

Relationship Status (required by insurance companies)
☐Single ☐Married ☐Partnership ☐Divorced ☐Separated ☐Widowed ☐Other _____

* **Emergency Contact** _____ Relationship _____ Phone ( ) ____-____
Name

Financial Responsibility *If you will be using insurance benefits, please complete this section.*

Name of Subscriber _____ Name of Client _____

Relationship to Subscriber _____

Preferred Phone ( ) ____ - ____ ☐ Cell ☐ Home ☐ Work ☐ Other _____

Email _____ ☐ Cell ☐ Home ☐ Work ☐ Email
Preferred Communication Method

Okay to leave a message on my ☐ Cell ☐ Home ☐ Work ☐ Other _____

Residential Address _____ City _____ Zip _____

Insurance Authorization ☐ I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier. I further authorize payment of insurance benefits for services rendered by Laura LaPointe, M.S., LMFT. I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

_____ _____
Initial **Date**

Private Pay ☐ I will not be using insurance. I will be paying out-of-pocket.

_____ _____
Initial **Date**

_____ _____ _____ _____
Client's Signature Date Therapist's Signature Date

Why are you seeking therapy? _____

What would you like to accomplish in therapy? _____

Have you had any prior counseling or psychiatric treatment? ☐ Yes ☐ No

When? _____ Therapist's Name _____

Phone ( ) ____ - ____

Reason for and length of counseling _____

When? _____ Therapist's Name _____

Phone ( ) ____ - ____

Reason for and length of counseling _____

Check One Response ☐ Therapy was helpful. ☐ Therapy was **not** helpful.

Please explain: _____

_____ _____

Initial **Date**

CURRENT STRESSORS

Name _____ Date ___/___/___

I am feeling stress now due to: (✔)

- ☐ Loss of a job or employment stress
- ☐ Relationship conflict or breakup
- ☐ Death of a family member or friend
- ☐ Trust issues, affairs, addictions
- ☐ Depression or anxiety
- ☐ Divorce or separation
- ☐ Trauma / Abuse
- ☐ Anger management struggle
- ☐ Problems with children, parents, in-laws
- ☐ Other _____

Please Check Behaviors and Symptoms You Are Currently Experiencing

- ☐ Aggression
- ☐ Alcohol Use
- ☐ Anger
- ☐ Anxiety
- ☐ Chronic Pain
- ☐ Compulsive Behavior
- ☐ Concentration Problems
- ☐ Cyber Addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug Dependence
- ☐ Eating Disorder
- ☐ Fatigue
- ☐ Flashbacks
- ☐ Grief
- ☐ Hallucinations
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood Swings
- ☐ Obsessive Thoughts
- ☐ Panic Attacks
- ☐ Phobias/Fears
- ☐ Poor Judgment
- ☐ Self-Esteem Problems
- ☐ Sexual Difficulties
- ☐ Sleep Problems
- ☐ Social Withdrawal
- ☐ Suicidal Thoughts
- ☐ Thoughts Are Disorganized
- ☐ Trembling
- ☐ Unresolved Trauma
- ☐ Worrying
- ☐ Other (Specify):

_____

_____ _____

Initial **Date**

DEPRESSION AND ANXIETY SCREENING

Name _____ Date ___/___/___

This is a list of some of the ways you may have felt or behaved recently. Please indicate how often you have felt this way during the past two weeks by checking (✔) the appropriate space.

	During the past two weeks:	Rarely or None of the time 0 - 1 Day	Some or a Little of the time 1 - 5 Days	Occasional/Moderate amount of the time 6 - 10 Days	Most or All of the time 11 - 14 Days
1	I have been bothered/irritated more often than usual.				
2	I have been overeating.				
3	I have not been eating much at all.				
4	I felt hopeless and helpless.				
5	I felt emotionally numb; I don't enjoy anything in life.				
6	I feel easily distracted and unable to concentrate.				
7	I felt I am inferior, a failure, worthless.				
8	I have nothing to look forward to in the future.				
9	I feel rejected by the people I love.				
10	I feel guilty about things a lot.				
11	I felt panic, racing heart, desire to run.				
12	I thought I was going crazy.				
13	I have insomnia. My sleep was interrupted / restless.				
14	I felt a lot of anxiety and worries.				
15	I wasn't interested in talking to loved ones / friends.				
16	I felt people wanted to hurt me.				
17	I lost all interest in my work and hobbies.				
18	I have lost my temper and have been aggressive.				
19	I have been very confused.				
20	I engaged in dangerous behavior.				
21	I thought about hurting or killing myself.				
22	I tried to hurt or kill myself.				

Initial **Date**

RELATIONSHIP EVALUATION

Please note: This portion of the assessment is only for those who are having a problem with a relationship. You can skip this section if you are not dealing with a relationship issue.

1 Are you having a relationship problem? ☐ Yes ☐ No

2 Who are you having the problem with? _____

3 How long has this problem lasted? _____

4 Do you feel respected/loved in your relationship? ☐ Yes ☐ No

Please explain. _____

_____

5 Do you think your partner/loved one feels respected and loved in your relationship? ☐ Yes ☐ No

Please explain. _____

_____

6 Please explain what you believe to be the main problem in your relationship. _____

_____

_____

7 How do you feel your partner/loved one contributes to the problem? _____

_____

_____

8 How do you feel you have contributed to the problem? _____

_____

_____

9 How do you rate your communication with your partner/loved one?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Bad

_____ _____

Initial **Date**

10 What are your communication problems or arguments mainly about? Check all that apply.

- ☐ Trust Issues i.e. (affairs or relationships with the opposite sex, including those involving social media)
- ☐ Communication misunderstandings
- ☐ Disrespect
- ☐ Lack of love and affection
- ☐ Anger management
- ☐ How to raise, educate, discipline, encourage and care for your children
- ☐ Finances - Budgeting, Income, Spending Limits
- ☐ Household Chores
- ☐ Recreational activities/hobbies
- ☐ Religious, political, or cultural beliefs/differences
- ☐ In-laws, extended family - grandparents, aunts, uncles, nieces, nephews, etc.
- ☐ Relationships with friends, blended or step-family issues
- ☐ Work/Career
- ☐ Legal problems
- ☐ Addictions
- ☐ Parent/child conflict, including adult children
- ☐ Other - Please explain _____

11 Explain how you argue about the issues you checked in item #10. _____

_____

_____

_____

_____

_____ _____

Initial **Date**

12 How did *your parents* or *those who raised you* resolve their conflicts? Check all that apply.

- ☐ Spoke respectfully and reached a compromise that both partners agreed to and took responsibility for.
- ☐ Yell, scream and blame each other.
- ☐ Blamed the other and pretend they were completely innocent and had no blame.
- ☐ Took all the blame and apologized for things that were not their fault.
- ☐ Pretended conflict never happened.
- ☐ Didn't deal with conflict directly, but gossiped, complained and were passive aggressive.
- ☐ Drowned their pain in alcohol, drugs, food, gambling, or some other addiction.
- ☐ Other - Please explain _____

13 Is there any similarity between the way you and your partner resolve conflict and your parents/guardians did?

_____

_____

_____

_____

_____ _____

Initial **Date**

MEDICAL / PHYSICAL HEALTH

Primary Care Physician

Name _____ Address _____

Phone ( ) - _____ City, State, Zip _____, CA _____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain.

_____

_____

CURRENTLY PRESCRIBED MEDICATIONS

1 _____ (Name) _____ (Dose) _____ (Frequency) _____ (Prescribed for)

Side Effects _____

2 _____ (Name) _____ (Dose) _____ (Frequency) _____ (Prescribed for)

Side Effects _____

3 _____ (Name) _____ (Dose) _____ (Frequency) _____ (Prescribed for)

Side Effects _____

4 _____ (Name) _____ (Dose) _____ (Frequency) _____ (Prescribed for)

Side Effects _____

5 _____ (Name) _____ (Dose) _____ (Frequency) _____ (Prescribed for)

Side Effects _____

_____ Initial _____ Date

MEDICAL CONDITIONS

Have you ever been diagnosed by a doctor with any of the following diseases, conditions or disorders? Check all that apply, and indicate if you are currently in treatment.

Notes

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Auto-Immune Disorder Lupus, Scleroderma, Multiple Sclerosis, etc.
- ☐ Brain Injury
- ☐ Cancer (What type?)
- ☐ Chronic Pain (Also Muscle or Bone Pain)
- ☐ Chron's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Hard of Hearing
- ☐ Heart Defect or Disease
- ☐ Hepatitis (A, B or C)
- ☐ Irritable Bowel Syndrome (Intestinal Problem)
- ☐ Kidney Problem
- ☐ Lung Disorder (COPD, etc.)
- ☐ Migrane Headaches
- ☐ Sclerosis of the Liver
- ☐ Sensory Processing Disorder
- ☐ Speech Problem
- ☐ Stroke
- ☐ Tics
- ☐ Vision Problem
- ☐ Other _____

Initial _____ Date _____

ALCOHOL AND SUBSTANCE USE

Do you drink alcohol? ☐ Yes ☐ No

Have you ever had a blackout? ☐ Yes ☐ No

Have you ever lost a job due to drinking? ☐ Yes ☐ No

Have you ever lost a relationship due to drinking? ☐ Yes ☐ No

Have you ever felt like you should cut down on alcohol or other drug use? ☐ Yes ☐ No

Has a friend or relative ever discussed concerns about your alcohol or drug use? ☐ Yes ☐ No

Is there a history of problems with alcohol or drug use in your family? ☐ Yes ☐ No

Who? What substance _____

Have you ever been treated for alcohol or drug dependence/abuse? ☐ Yes ☐ No

If Yes,

When? _____

Where? _____

Check One Response ☐ Treatment was helpful. ☐ Treatment was **not** helpful.

Please explain: _____

_____

_____

Do you take street drugs? ☐ Yes ☐ No

☐ Marijuana	☐ Heroin	☐ Morphine	☐ Salvia
☐ Tranquilizers	☐ Hallucinogens	☐ Muscle Relaxers	☐ Percocet
☐ Hypnotics	☐ Benzodiazepines	☐ Ecstacy	☐ Glue
☐ Designer Drugs	☐ Meth	☐ PCP	☐ Inhalents
☐ Opioids	☐ Bath Salts	☐ Oxycodone	☐ Other _____

_____ _____

Initial **Date**

How often do you take street drugs and for what reason? _____

_____

What is the usual dose? Any side effects? _____

_____

_____

Have you ever had a hallucination? Was it auditory, visual, tactile (touch), or olfactory (smell)?

_____

_____

Have you ever had a delusion? ☐ Yes ☐ No

Has anyone every told you that you are paranoid? If so, who, and under what circumstances?

_____

_____

_____

How are your eating habits? Do you overeat? Have you gained or lost weight in the last 3 months? If so, how much did you lose or gain?

_____

_____

_____

Do you exercise? What type of exercise do you do? How often?

_____

_____

_____

_____ _____

Initial **Date**

Do you have any health problems?

How do you sleep? Do you have any problems going to sleep or staying asleep? How many hours of sleep do you get every night? Do you have frequent nightmares?

Do you ever have days where you don't have to sleep and you can stay up with no problem for days without naps?

Do you have any legal problems?

What are your greatest strengths?

What would you say are your weaknesses?

Initial _____ Date _____

Do you have any questions for me?

Is there anything else that I need to know to be able to understand you better?

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____