Cassie Salewske, MA LMHC ACHt
Healing Tree Counseling and Wellness, LLC
2528 Wheaton Way, Suite 204, Bremerton WA 98310
www.cassiesalewske.com
206-595-8621

NEW CLIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

Full Name: _____

Name you prefer: _____ Pronoun Preference: _____

Age: _____ Date of Birth: _____

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Trans ☐ Other: _____

Sexual Orientation: ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Hetero ☐ Queer ☐ Other: _____

CONTACT INFORMATION

Street Address: _____ Unit or Apt #: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Cell Phone Number: _____ May I leave a message? ☐ Yes ☐ No

RELATIONAL INFORMATION

Current Relationship Status: _____

If Partnered/Married, how long: _____ If Separated or Divorced, how long: _____

With whom do you currently live? *(Check all that apply)*

☐ Alone ☐ Spouse/Partner ☐ BF/GF/SO ☐ Children (#____) ☐ Parent(s) ☐ Sibling(s)

☐ Other: _____

PRESENTING ISSUES

Please tell me why you are seeking counseling:

MENTAL HEALTH HISTORY

Have you been previously diagnosed with a mental health/psychiatric condition? ☐ Yes ☐ No

If Yes, please list: _____

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Have you experienced suicidal thoughts in the past? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If Yes, when: _____

Have you had any previous psychiatric hospitalizations? ☐ Yes ☐ No

If Yes, when and where: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Are you currently receiving medical treatment? ☐ Yes ☐ No

If Yes, please specify: _____

Please list any major conditions, illnesses, surgeries, or injuries you've had:

_____

Current Medications: Dosage: Taking for:

_____

_____

_____

_____

REFERRAL SOURCE

How were you referred to me? ☐ Online Directory ☐ Website ☐ Friend/Family ☐ Other

Name of person/directory/other: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signature: _____ Date: _____

Confirmation of Informed Consent

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Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Cassie Salewske, MA LMHC ACHt and I understand it.

_____ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

_____ I agree to follow the terms in the Disclosure Statement.

_____ I give my consent for treatment as outlined in this Disclosure Statement.

_____ Telehealth Sessions: I understand and agree to abide by the 24-hour cancellation policy. I understand that if I do not give 24 hours' notice I will be billed $40.00 for the session I cancelled or missed.

_____ In-Person Sessions: I understand and agree to abide by the 24-hour cancellation policy. I understand that if I do not give 24 hours' notice, I will be billed $75.00 for the session I cancelled. I understand I will be billed the full session fee for any missed ("no show") appointments.

_____ I understand that my therapeutic relationship with Cassie Salewske may be discontinued if the terms in this agreement are not fulfilled by either of us.

Client Name

Client Signature

Date

This form will be retained in the mental health record.

Acknowledgement of Receipt of Notice of Privacy Practices

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By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Cassie Salewske, MA LMHC ACHt.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of Cassie Salewske, MA LMHC ACHt with respect to my protected health information.

_____ _____
Signature of Client Date

This form will be retained in the mental health record.

*** * * FOR OFFICE USE ONLY * * ***

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the Acknowledgment
☐ An emergency situation prevented me from obtaining Acknowledgment
☐ Other:_____