

## Intake Form

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number (SSN):** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Ok to leave message? Phone:** yes no **Text:** yes no **Email:** yes no

**Gender:** \_\_\_\_\_ **Sexual Orientation:** \_\_\_\_\_

**Race/Ethnicity:** \_\_\_\_\_

**Marital/Partnered status:** \_\_\_\_\_

**Children? Yes No**

**If yes, names and ages:** \_\_\_\_\_

\_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

**Plan Name:** \_\_\_\_\_

**Policyholder's Name:** \_\_\_\_\_

**Policyholder's Date of Birth:** \_\_\_\_\_

**Policyholder's ID Number:** \_\_\_\_\_

**Policyholder's Group Number:** \_\_\_\_\_

**Policyholder's Employer:** \_\_\_\_\_

**Malia Parecki, LCSW, CMHS**

4605 NE Fremont Ave Portland #210E

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**Insured's Policy or ID Number:** \_\_\_\_\_

**Insured's Group Number:** \_\_\_\_\_

**Deductible/Co-pay/Coinsurance:** \$ \_\_\_\_\_ \$ \_\_\_\_\_ % \_\_\_\_\_

**Insurance Billing Address:** \_\_\_\_\_

\_\_\_\_\_

**Insurance Phone:** \_\_\_\_\_

\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy or ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Co-pay:** \_\_\_\_\_

**Secondary Insurance Billing Address:** \_\_\_\_\_

\_\_\_\_\_

**Secondary Insurance Phone:** \_\_\_\_\_

Insurance companies vary in the confidential information they require in order to pay for services. In addition to information regarding diagnosis and dates of service, some insurance providers will request treatment plans, progress reports, or session notes.

Your signature below indicates that you have read and understood all of the above material and consent to have Malia Parecki, LCSW, CMHS release your confidential information as needed to collect payment from your insurance.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**Primary Care Provider's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**When was your last check-up?** \_\_\_\_\_

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**\*\*NOTICE: The person you identify as your emergency contact is someone Malia Parecki can contact in order to coordinate your care in case of psychological crisis or emergency. You will be informed of the intent to contact if the need arises.\*\***

**Emergency contact: Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

In your own words, please explain why you are seeking therapy at this time:

Are there any special, unusual, or traumatic circumstances in your life history? (ex: abuse, neglect, violence, and/or assault, natural disasters)	Y	N
Have you ever experienced family violence, either as a perpetrator, victim, or witness?	Y	N
Have you ever seen a mental health provider before?	Y	N
Is there anyone in your immediate family (parents, siblings, grandparents, aunts/uncles, cousins) with a history of mental health issues, including substance abuse?	Y	N
Do you currently have, or in the past couple of weeks have you had, thoughts or feelings about ending your life?	Y	N
Have you felt hopeless lately, like things wouldn't improve or get better?	Y	N
Have you <b>ever</b> attempted suicide?	Y	N
Are you currently being evaluated or treated for any physical complaints, pains, or illnesses?	Y	N
Do you have a history of any out-of-the-ordinary illnesses?	Y	N
Do you have any health-related concerns that you are not currently being treated for?	Y	N
Have you ever been in legal trouble as a result of drinking or substance use?	Y	N
Do you think your use of alcohol and/or drugs is interfering with your social relationships, job performance, family life, school work, and/or other responsibilities?	Y	N
Has anyone ever thought you should reduce or stop your use of substances?	Y	N
Has there ever been a time when people either thought you were too thin or were losing too much weight?	Y	N
Have you ever felt out of control and gone on eating binges during which you ate an abnormally large amount of food?	Y	N
Has there ever been a time, lasting at least a few days, during which you felt hyper, charged up with energy, or very high and you felt this was significantly	Y	N

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different from your usual self?		
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If your life was as you want it to be, what would be different?

**In the last few weeks, have you experienced any of the following?  
Circle all that apply:**

- Sleep difficulties (including too much)    Lack of interest in activities    Guilty feelings  
Difficulty concentrating    Change in physical activity level    Low energy  
Weight gain or loss    Changes in appetite

**Please list all medications and over the counter medications and/or supplements  
you currently take:**

Medication/Supplements:	Dose	Prescribed/recommended by:

# General Information and Client Consent Agreement

## Introduction

Please take your time and read all sections of this disclosure form carefully. Feel free to ask any questions you might have.

## Your Rights

You have the right at any time during the course of treatment to request a change of therapy, request a referral for another therapist, or to discontinue therapy for any reason.

## Your Responsibilities

- It is important for you to be actively involved in all aspects of treatment including:
- Attending sessions (or letting Malia know when you can't make it)
- Voicing your opinions, thoughts, and feelings, honestly and openly, whether negative or positive
- Being actively involved during sessions
- Doing between-session work as requested
- Experimenting with new behaviors and new ways of doing things

## About Your Therapist

Malia Parecki, LCSW, CMHS earned a Master's in Social Work (MSW) from Portland State University in 2008. She has worked as a mental health therapist for individuals, groups, and families since 2002. She is trained to work with people experiencing Depression, Anxiety, Post-Traumatic Stress Disorder, attachment-based concerns, and survivors of abuse/neglect. She works with people across the lifespan, including children, adolescents, adults, and older adults. Malia Parecki is a Licensed Independent Clinical Social Worker (**L4982**) and Child Mental Health Professional in Washington State.

## Therapeutic Orientation

I use an integrated approach including aspects of psychodynamic, CBT, EMDR, attachment-based and multicultural therapies as well as mindfulness techniques.

## Course of Treatment

Therapy does not necessarily proceed in a neat, sequential, progressive series of steps nor are the stages a predictable length. However, in general there are four steps to therapy.

Assessment: Your therapist will gather your history and work to understand experiences which have impacted you. We will identify goals and agree to collaborate on the problem at hand.

Skill building: You will build skills for managing thoughts and emotions that are overwhelming so you have the tools you need to go deeper into your work.

Insight: We will work together to help you see issues more clearly and see your situation or role differently.

Reorientation: You will work in your everyday life to reinforce new insight and create the life that better fits your deeper understanding of yourself, your experiences, and your current goals.

If you feel that you are not being helped by therapy or need to terminate therapy for some reason, please discuss this with Malia Parecki at any time during treatment. Malia Parecki may also

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request termination if she feels that she is no longer able to help you. However, therapy will never be terminated without discussing these issues with you first.

Treatment Risks

Some clients experience an increase in stress particularly near the onset of therapy. It is not unusual for clients to feel worse before feeling better.

Financial Agreement

Services are charged on an hourly or per session basis. The fee per 50-minute session is \$ 125 (except for the first session which is \$175). This is payable at the time of our session, unless I have agreed to bill your insurance plan. There will be a \$15.00 service charge for each non-sufficient funds check. Accounts are not to accrue any unpaid balance of more than two sessions. After two sessions of unpaid balances, services may be withheld until the account is paid in full. Past due balances may be turned over to a collections agency.

Cancellations, Missed Appointments, and Lateness

A 24-hour advance notice of cancellation for scheduled appointments is required. A \$125 fee will be charged for missed sessions not canceled 24 hours in advance. Note: Your insurance will not pay for missed or cancelled sessions, so you will be responsible for paying out of pocket. In addition, if you are more than 20 minutes late, your insurance will not pay for the full session, and you will be responsible for the remainder of the full fee. All messages, including cancellations, may be left on Malia Parecki's voicemail or via text message at (503) 310-6845 or via email at pareckicounseling@gmail.com.

Records

Your records are confidentially maintained in a locking filing cabinet and are placed in secure storage upon termination of services. Each patient's file and records are maintained personally by Malia Parecki.

**Please retain a copy of this agreement for your files.**

Your signature below indicates that you have read and understood all of the above material and are willing to work within the parameters of Malia Parecki's policies and procedures.

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Client Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

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Parent/Guardian/Conservator Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

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Malia Parecki, LCSW, CMHS \_\_\_\_\_ Date \_\_\_\_\_

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## **Email and Text (SMS) Messaging Informed Consent**

In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them.

I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my e-mail communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information we send via e-mail. I understand that SMS messages are even less secure than e-mail, and the same conditions apply. I understand that for this reason my therapist has advised me not to send sensitive information via email or SMS message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.

I hereby give permission for my therapist to reply to my messages via e-mail, including any information that my therapist deems appropriate, that would otherwise be considered confidential. I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet.

I understand that my therapist will limit SMS messages to brief inquiries or responses regarding scheduling. I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail. I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use e-mail but will call my therapist. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call my therapist. I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or SMS by notifying my therapist in writing.

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Client's Signature

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Parent/guardian's Signature (if client is a minor):

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Date