Soha Dardashti, LMFT 86064

1355 Westwood Blvd., #9

Los Angeles CA 90024

Tel. (310) 592-5921

Adult Intake

Please fill out this form and bring it to your first session.

Name ______________________________

Birth Date: __________ Age: __________ Gender: Male Female

Marital Status: __________

Please list any children/age/gender: ______________________________

____

Address: ______________________________

Phone number: ______________________________

Referred by: ______________________________

Person to Contact in case of an emergency:

Name: ______________________________

Phone number: ______________________________

Relationship to you: ______________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, duration of treatment and reason for seeking therapy

Are you currently taking any prescription medication?

Yes

No

Please list name(s) /dosage/diagnosis:

Have you ever been prescribed psychiatric medication?

Yes

No

Please list and provide dates and diagnosis:

General Health and Mental Health Information:

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate you current sleeping habits?

Hours of sleep you get on average ____________

Do you sleep through the night? ____________

Do you experience any nightmares? ____________

Do you feel rested when you wake up in the morning?

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

Please list any changes to your appetite/weight during the past 6 months.

4. Please circle if you have been experiencing any of the below:

Sadness grief depression anxiety panic attacks phobia
Loss of interest change in energy level

If yes, please explain ____________________

5. Do you drink any alcohol?

If yes, how often ____________________

6. Do you engage in any recreational drug use?

If yes, please list type and frequency ____________________

7. Do you smoke cigarettes? ____________________

8. Are you currently in a romantic relationship?

If yes, for how long? ____________________

How would you rate your relationship?

Poor Satisfactory Good Very good

9. What significant life changes or stressful events have you experienced recently:

____
____
____
____
____

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List family Member
Alcohol/substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorder	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	

Additional Information:

1. Your highest level of education:

Year degree obtained:

2. Are you currently employed?

If yes, what is your current employment situation: ____________________

3. Do you consider yourself to be spiritual or religious?

If yes, describe your faith or belief: ____________________

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses?

6. What would you like to accomplish out of your time in therapy?

Legal Issues

1. Have you personally experienced Legal problems? If yes describe:

2. Are you currently involved in a lawsuit? If yes describe:

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Informed Consent for treatment:

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information About Your Therapist:

Soha Dardashti is a Licensed Marriage Family Therapist (LMFT 86064). Soha Dardashti earned her Master of Science in Psychological Counseling with emphasis on Marriage Family Therapy from California State University of Northridge with Distinction in 2008.

Fees and Insurance:

Sessions are approximately 50 minutes in length

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

Fee per session agreed with client and therapist prior to first session is **$**.

Confidentiality:

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family

therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

Please feel free to ask your therapist about her “no secrets” policy and how it may apply to you.

Minors and Confidentiality:

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies:

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours’ notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Communication with Therapist:

You are always welcomed to call your therapist and leave a message to be contacted. Please allow approximately 12 hours for therapist to call back. Please refrain from sending text messages/emails to your therapist containing confidential information. Soha Dardashti will not send you text/emails discussing clinical/confidential matters.

About the Therapy Process:

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy:

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents, (giving consent for treatment of your minor child/yourself) as it applies to Soha Dardashti. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Name of Client (please print)

Name of Custodial parent (If client is under 18 years of age)

Signature of Client

Signature of Parent (if client is under 18 years of age) **Today's date**