



California Mental Health Counseling Associates

559 West 9th Street

San Pedro, CA 90731

Ph & Fax: 877.497.6622

Please print and complete the following client information form as thoroughly as possible and sign and date it.

Also, print and read the informed consent thoroughly, then sign and date where indicated.

Once completed, you may fax them to:

1-877-497-6622

or

Mail them to:

CMHCA

P.O. Box 648

San Pedro, CA 90733



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San Pedro, CA 90731

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Client Intake Form

Name: _____ D.O.B. ___/___/___ Age: _____ Date: ^{Today's} ___/___/___
 Address: _____ Gender: M/F Height: _____ Weight: _____
 _____ Race/Ethnicity: _____ Marital Status: _____
 _____ SS#: _____

Home Phone#: (____) _____ Other Phone#: (____) _____
 Occupation: _____ Income: \$ _____/year/hour Household Income: \$ _____/year

Current Living Arrangements (people living with you) _____ Email: _____

NAME	AGE	RELATIONSHIP

Date of last physical exam: _____ Current Doctor: _____ Phone#: (____) _____

Current medical conditions: _____

Current medications: _____

Significant prior medical conditions: _____

Prior mental health treatment: _____

Current reason for seeking treatment: _____

X _____ Date: ___/___/___

Signature



INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

I, _____, have been referred for mental health treatment as a client of California Mental Health Counseling Associates and I have been informed of the following:

- The condition for which I will be receiving treatment;
- The proposed interventions and treatment (informed consent for medications on another form);
- The potential benefits, risks and side effects of the proposed interventions or treatment;
- The problems related to recovery;
- The likelihood of success;
- Any significant alternative treatment or interventions;
- My rights, to the extent permitted by law, to refuse medications, treatment or interventions.

RULES AND POLICIES OF MENTAL HEALTH TREATMENT

Additionally, I agree to abide by the treatment policies and rules, which include the following:

1. Clients are expected to take all medications prescribed by psychiatrist or a primary physician while in treatment. Exceptions to the above must be reported to your primary therapist immediately.
2. Clients are expected to attend individual and group therapy, and all other adjunct treatment as determined by you and your therapist. If you cannot attend a scheduled session, you are expected to contact your therapist to reschedule at least 24 hours prior to the session.

I HAVE BEEN INFORMED OF THE ABOVE AND AGREE TO THE TREATMENT. I AGREE TO COMPLY WITH THE RULES AND POLICIES. I UNDERSTAND THAT REFUSAL TO COOPERATE WITH TREATMENT RULES AND POLICIES WILL RESULT IN CONSEQUENCES, WHICH MAY INCLUDE TERMINATION FROM TREATMENT.

Signature _____	Date _____
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CONFIDENTIALITY

California Mental Health Counseling Associates staff maintain client confidentiality in regard to all medical issues, including mental health treatment. However, clients are advised of the following exceptions:

1. Suspected or known child, dependent or elder abuse must be reported to the appropriate agencies.
2. Threats to harm someone must be reported to the police and to the intended victim.
3. Danger to self.

I UNDERSTAND THE EXCEPTIONS TO CONFIDENTIALITY.

Signature _____	Date _____
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SERVICES PROVIDED

California Mental Health Counseling Associates provides the following mental health services:

Bio-psycho-social evaluation;

- Individual therapy—emphasized increasing insight, psycho-education, relapse prevention, cognitive-behavioral interventions, self-sufficiency, goal setting, goal attainment, development of social support, acquisition of daily functioning skills and development of interpersonal relations;
- Couples therapy;
- Family therapy;
- Group therapy.

PAYMENT FOR SERVICES

Clients are expected to pay for services on the day they are rendered.

COMPLAINTS/GRIEVANCES

Clients may file a complaint/grievance concerning any aspect of their care and treatment. You are encouraged to discuss any concerns you have with your primary therapist first. If this is not possible or yields no results, please contact CMHCA administrative staff. If you are still unable to get your concerns resolved contact the California Association of Marriage and Family Therapists at (858) 292-2638 or www.camft.org.

CLIENT RESPONSIBILITIES

Providing Information

- You are responsible for providing, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your mental health.
- You are responsible for reporting any perceived risks in your care and any unexpected changes in your condition.
- Your feedback about your service needs and expectations are welcomed and deemed very important in order for us to improve our ability to meet the safe and effective treatment needs of our clients and to gain an understanding of the client environment.
- You are responsible for asking questions when you do not understand what you have been told about your care or what you are expected to do.

Following Instructions

You are responsible for following the care, service or treatment plan developed. You should express any concerns that you have about your ability to follow and comply with the proposed treatment plan. Every effort will be made to adapt the plan to your specific needs and limitations.

Accepting Consequences

You are responsible for the outcomes of your care if you do not follow the care, service or treatment plan.

Showing Respect and Consideration

You are responsible for being considerate of agency staff, agency property, other clients and other clients' property. California Mental Health Counseling Associates does not tolerate any violence from its employees and patients whether it is verbal or physical in nature. You are strongly encouraged to advise staff if you begin to feel anxious, angry or fearful anytime while you are here. This will allow the treatment team to work with you individually to meet your specific needs and for us to provide the best care, welfare, safety and security for all. Thank you for your anticipated cooperation and we hope to ensure your mental healthcare needs are met to your satisfaction.

I UNDERSTAND THE SERVICES PROVIDED, PAYMENT REQUIREMENTS, THE RIGHT TO FILE GRIEVANCES/COMPLAINTS AND MY RESPONSIBILITIES.

Signature _____	Date _____
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