Welcome to Desert View Family Counseling Services

Please note that this information is important for your care. Please fill out forms as completely as possible.

ADULT INTAKE FORM
Group Intake
Please PRINT all information

CLIENT INFORMATION

Name: ________________________________ Date of Birth: _____________ Age: _____________

What is your gender identity? ☐ Male ☐ Female ☐ Transgender ☐ Gender Non-Conforming

What sex were you assigned at birth? ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Other

Address (mailing): ____

City, State, Zip____

Home Phone: _______________ Work Phone:___________________ Cell Phone: ______________

Email Address: ____

Referral Source: ☐ Probation ☐ CYFD ☐Attorney ☐ Other ______________________________

PLEASE CHECK OTHER PROBLEM AREAS FOR WHICH YOU ARE SEEKING HELP:

	Abused as Child		Depression		Marital Conflicts
	Adult Victim/ Witness DV		Divorce		Mood Swings
	Aggression / Violence		Drug Abuse		Ovsessions
	Alcohol Abuse		Eating Problems		Physical Abuse
	Anger Problems		Excessive Stress		Problems with Law / Courts
	Anxiety		Fighting		Self-esteem
	Behavioral Problems		Grief		Sexual Abuse
	Childhood Issues		Homeless		Sleep Problems
	Codependence		Hyperactivity		Suicidal Thoughts/ Actions
	Defiance		Impulse Control Problems		Work Problems

☐ Substance Abuse Group ☐ Life Skills / Anger Management Group ☐ Parenting Group

_______________________________________ _______________________

Client Signature Date

CONSENT TO TREAT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Desert View Family Counseling. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. Probable consequences of not receiving treatment

2. **Clinical Supervision**: Your case may be staffed with the clinical director and/or other licensed therapist within the agency. This is to ensure the best possible outcome for you and your family.

3. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Desert View Family Counseling, and I consent to disclosure for use by Desert View Family Counseling staff for the purpose of continuity of my care. Per New Mexico mental health law, information provided will be kept confidential with the following exceptions: 1) if it is deemed that I present a danger to myself or others; 2) if concerns about possible abuse arise from an intimate partner or household member; or 3) if a court order is issued to obtain records.

4. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

5. **Sessions** are between 45 and 50 minutes long.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

7. **Desert View Family Counseling reserves the right to refuse service to anyone.**

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself. I understand that I have the right to ask questions to my service provider about the above information at any time.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Guardian Signature (if patient is under 18) Date

______________________________ ______________
Signature of witness Date