Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Gender  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to email you here? Yes No

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   OK to call you here?   Yes    No

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   OK to call you here?   Yes    No

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    OK to call you here?   Yes    No

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We currently have a Spanish-speaking counselor on our staff.

Are you interested in being paired with her? Yes No

How did you hear about STA? Please circle all that apply.

Friend Current STA Client Doctor Internet search/Website

Family member Former STA Client Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Need**

Please provide a brief description of your reasons for seeking counseling at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How have these concerns evolved over time?

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What are your goals for our counseling work?

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Please circle any of the following struggles that pertain to you:

Anxiety  Depression  Fears/Phobias  Eating Disorders

Sexual Problems           Sexuality Sexual Orientation Suicidal Thoughts

Separation/Divorce       Relationships Finances             Drug/Alcohol Use

Career Choices            Stress Anger Self Control

Unhappiness              Insomnia             Religion/Spirituality Grief

Gender Transition    Thought Patterns Oppression Cutting/Self-Mutilation

**History of Care**

Are you currently under medical care?  Y / N If yes, then please explain/describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Information of Personal Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed medications?  Y / N

If yes, then please explain/describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any psychiatric/mental health medications you have taken.

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Have you been under the care of a psychiatrist, psychologist, or counselor?  Y / N

If yes, please give the name and date of the therapy and briefly explain the nature of the problem that required attention.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized for a mental health condition?  Y / N

If yes, please give the date and briefly explain the nature of the problem that required attention:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been in a drug or alcohol treatment program?  Y / N

If yes, please give the facility, length of time in treatment and outcome:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently drink alcohol?  Y / N How much? \_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_

Do you currently use recreational drugs?  Y / N How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What substances?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have a problem with either alcohol or drugs?  Y / N

Have you ever attempted or considered suicide?  Y / N If yes, please provide some details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you want your therapist to know prior to our beginning your treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Counseling Fee**

STA provides low-cost therapy for all women regardless of your level of income, however STA is unable to provide free services, and insurance will not be billed for sessions. See STA’s Disclosure Statement for more information.

Please comment on your ability to meet your obligation of $35-$65 weekly for therapy services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Schedule**

Seattle Therapy Alliance has a number of counseling times available, and we do our best to offer clients an appointment time within their availability. Scheduling availability is however one factor in the extension of an invitation for involvement in the Project.  Please indicate below the days/times you are available to see a therapist by checking the appropriate times.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Time | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| 8am |  |  |  |  |  |  |
| 9am |  |  |  |  |  |  |
| 10a |  |  |  |  |  |  |
| 11am |  |  |  |  |  |  |
| 12pm |  |  |  |  |  |  |
| 1pm |  |  |  |  |  |  |
| 2pm |  |  |  |  |  |  |
| 3pm |  |  |  |  |  |  |
| 4pm |  |  |  |  |  |  |
| 5pm |  |  |  |  |  |  |
| 6pm |  |  |  |  |  |  |
| 7pm |  |  |  |  |  |  |
| 8pm |  |  |  |  |  |  |

What would your *ideal* appointment time be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We believe healing and change most often occurs slowly and over time, therefore STA counselors offer long term counseling. How certain are you, on a scale of 1 to 10, that you will be able to commit to weekly therapy for a period of up to one year? (1 being completely uncertain and 10 being completely certain)

**1   2 3 4 5 6   7 8 9  10**

**\*\*Please be aware that if you are not able to protect the particular time that is agreed upon, we will not be able to guarantee you another counseling spot.**

Seattle Therapy Alliance

Please return this form to: Attn: Jessi Johns Bowling

[Intake@seattletherapyalliance.com](mailto:Intake@seattletherapyalliance.com) or 200 1st Ave W. Suite 400

Seattle, WA 98119

Thank you for submitting your application!