

# Client Intake Information

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1. CLIENT(S) NAME: (1) \_\_\_\_\_ AGE: \_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_ - \_\_\_ - \_\_\_\_\_  
(2) \_\_\_\_\_ AGE: \_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_ - \_\_\_ - \_\_\_\_\_  
(3) \_\_\_\_\_ AGE: \_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_ - \_\_\_ - \_\_\_\_\_

2. OTHERS IN HOUSEHOLD:

NAME	DOB/AGE	RELATIONSHIP	OCCUPATION	EDUACTION LEVEL
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. ADDRESS: \_\_\_\_\_ ZIP: \_\_\_\_\_

4. PHONE: (home): \_\_\_\_\_ (office): 1 \_\_\_\_\_ 2 \_\_\_\_\_

5. RELATIVE/FRIEND TO CONTACT IN EMERGENCY: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

6. REFERRED BY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

7. MARITAL STATUS: \_\_\_\_\_ EDUCATION: (1) \_\_\_\_\_ (2) \_\_\_\_\_

8. CHURCH MEMBERSHIP: (1) \_\_\_\_\_ (2) \_\_\_\_\_

9. EMPLOYER: (1) \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
(2) \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
(3) \_\_\_\_\_ HOW LONG? \_\_\_\_\_

10. OCCUPATION: (1) \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
(2) \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
(3) \_\_\_\_\_ HOW LONG? \_\_\_\_\_

11. GROSS FAMILY INCOME: \_\_\_\_\_

12. FAMILY OR PERSONAL PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

13. RACE: Native American \_\_\_\_\_ Asian \_\_\_\_\_ Black \_\_\_\_\_ Caucasian \_\_\_\_\_ Hispanic \_\_\_\_\_

14. INSURANCE CARRIER NAME: \_\_\_\_\_

15. AMOUNT DEDUCTIBLE: \_\_\_\_\_ % COVERED: \_\_\_\_\_

16. POLICY/GROUP NUMBER: \_\_\_\_\_

# Individual Client Information

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TO BE COMPLETED BY EACH PARTICIPATING CLIENT (use reverse side or multiple prints if necessary)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

1. Reason(s) for seeking counseling services at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. What would you state as the major problem(s) you are coming to treatment for?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. What I want to accomplish in counseling (goals for therapy): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Do you have any medical problems? Yes\_\_\_ No\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
5. In the past year, have you ever drunk or used more drugs than you meant to?  
Yes\_\_\_ No\_\_\_
6. Have you ever felt you wanted or needed to cut down on your drinking or drug use in the last year? Yes\_\_\_ No\_\_\_
7. Are you afraid that you or anyone else might be harmed? Yes\_\_\_ No\_\_\_ If yes, please explain: \_\_\_\_\_
8. Have you been abused? Yes\_\_\_ No\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
9. Previous experience in counseling, psychotherapy, psychological or psychiatric examination/treatment: Date(s), Therapist(s), Reason(s):  
First Time: \_\_\_\_\_  
Second Time: \_\_\_\_\_
10. Do you sleep well? Yes\_\_\_ No\_\_\_ Do you eat well? Yes\_\_\_ No\_\_\_  
How often do you exercise? \_\_\_\_\_ times per month/week (circle one)
11. Have you ever thought of or attempted suicide within the last 12 months?  
Yes\_\_\_ No\_\_\_
12. Have you thought of harming/hurting another in the past 12 months?  
Yes\_\_\_ No\_\_\_
13. Have you ever been arrested, had legal problems or suspended from a job or school? Yes\_\_\_ No\_\_\_ When? (Year): \_\_\_\_\_ Please Explain: \_\_\_\_\_  
\_\_\_\_\_

# Disclosure Statement

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Francis Gaebler is a licensed Psychologist in the State of Colorado and holds a doctoral degree in clinical psychology (University of Denver, 1980). He was first licensed as a Psychologist in July 1984.

A qualified psychologist practices specific methods of treatment and can explain what techniques will be used. Although the exact length of treatment is hard to predict, a psychologist will tell you his/her average treatment duration for conditions similar to yours, if known. You have the right to know if other treatments are available. You are encouraged to discuss your process of treatment and are reminded that you may end treatment at any time. You may also seek a second opinion if you wish to do so. A psychologist can guide you as to the effectiveness of alternatives. Dr. Gaebler views psychotherapy as a cooperative process and encourages you to question all techniques and directions of your treatment.

A qualified psychologist may consult with other experts on treatment issues. Dr. Gaebler reviews his clients' treatment plans with his colleagues in weekly clinical staff meetings. These meetings are confidential; however you may request that your name remain completely anonymous.

The information provided by you during therapy is legally confidential except as required by law. There are exceptions which can be discussed and will be identified should any such situation arise during therapy. (Exemptions to confidentiality include "Threat of serious harm to self or others," as in the case of child abuse, suicide or grave disability.) Couples, by signing you agree NOT to use any information revealed in sessions against your partner if the marriage ends.

Please be on time for all appointments. If you need to make a change in schedule, please notify Dr. Gaebler 24 hours in advance. Without 24 hour notice, clients will be charged full fee for all broken or missed appointments. Emergencies are exceptions.

Sexual contact between patient and therapist is not part of any recognized therapy. Sexual intimacy between patient and therapist is illegal in Colorado and should be reported to the Grievance Board.

The State Department of Regulatory Agencies can help you identify a licensed psychologist. If you have any concern or complaints about licensed mental health practitioners, you can contact the State Grievance Board.

1560 Broadway, #1370  
Denver, Colorado 80202  
Phone: (303) 894-7766

You are kindly requested to pay all fees at the end of each treatment session. Alternative payment schedules are possible and should be discussed ahead of time. Therapists have a formal responsibility to our clients to provide therapeutic services when such services are needed. We DO NOT, however, have a contractual agreement with your insurance company. In accepting counseling services, clients agree to incur legal financial responsibility for the cost of those services.

Counseling services are usually considered a medical expense and therefore are frequently covered by private health insurance plans. Often a diagnosis is required in order to establish insurance coverage. As soon as possible, please notify your insurance carrier and complete the enclosed insurance forms. By signing the below, you agree for Dr. Gaebler to submit insurance forms and list your current diagnosis and supporting mental status, if necessary.

I understand that the fee for this service is \_\_\_ per 50-minute hour. Any session over (1) hour is charged by the quarter hour. Please pay the full fee at the end of each session. I/we will receive counseling beginning \_\_\_\_\_. I/we will be responsible for ALL monies not covered by insurance: co-payments, deductibles, and any money your insurance company fails to pay within (2) months.

ADDENDUM(S):

PAYMENT AGREEMENT REGARDING PRIVACY OF RECORDS

I understand that Francis X. Gaebler, Psy.D. may only disclose my protected health information to physicians, insurance companies, payment services, or other healthcare providers with my permission, except limited circumstances which are specified in his Privacy Practice Notice.

I understand that he is required by federal and state laws to safeguard the privacy of my health information. I understand that I have the right to look at or get copies of my health information, with limited exceptions. I understand that I may request a copy of his Privacy Practice Notice for my review.

I understand that he may change his privacy practices at any time, in accordance with applicable law, and that I will be informed of such changes if I am an active patient at the time.

I have been informed of my therapist's degrees, credentials, and licenses. I have read the above disclosure statement and understand my rights as a client.

\_\_\_\_\_  
Client Date

\_\_\_\_\_  
Therapist Date

\_\_\_\_\_  
Client Date

Dr. Francis X. Gaebler, Psy.D.  
Licensed Clinical Psychologist - Colorado  
Office: (970) 495-6567  
Emergency Only: 1-877-778-2844 or (970) 223-8394  
- or call co-workers through answering service  
- or call "911"  
- or go to the emergency room nearest you

**Please Initial and Date If Applies To You:**

\_\_\_\_\_  
Initials Date I am aware that Dr. Gaebler, Psy.D. is NOT a provider for Medicare, Medicaid and that you will not be able to submit for reimbursement for these services.