Miles Graham Salisbury, LPC
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Intake Form

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

□ Medical Provider:
_____

□ Insurance Provider:
_____

□ Website at http://www.milessalisbury.com
□ Psychology Today website
□ Friend/Family:
_____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Please provide:

Name of provider or facility:
_____

Location:
_____

Dates of treatment:
_____

Reason for treatment:
_____

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

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

Family History

Where were you born?

_____

Where did you grow up?

_____

□ city □ suburbs □ country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

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 (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive	yes/no	
Behavior		
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:

□ Never Married

□ Domestic Partner □ Married

For how long?_____

Please give partners name: _____

On a scale of 1-10 (best), how would you rate your relationship? _____

□ Separated □ Divorced □ Widowed

If widowed, please give partners name, and year deceased:

_____

Are you currently in a romantic relationship? □ No □ Yes If

yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information:
Name:
_____

Specialty:
_____

Facility:
_____

Phone, email, or Fax:
_____

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:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise to you participate in?

Please list any difficulties you experience with your appetite or eating patterns:

_____

Any change in weight over the past year? □ No □ Yes:

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

Miles Graham Salisbury, PhD, LPC

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Disclosure of Information

My approach to psychotherapy comes from the belief that people are basically good and inherently benevolent. When one has feelings of depression, anxiety, or any other psychiatric symptom, this goodness has simply been confused, lost, or buried. A mix of client centered, existential, psychodynamic, Jungian, technique, as well as others informs my approach to psychotherapy.

I have a Doctoral degree in Psychology with a specification in Depth Psychology and psychotherapy from Pacifica graduate institute. Major coursework completed includes: Jungian psychotherapy, psychodynamic psychotherapy, diversity, group practicum, dream analysis, and others. I hold a Master's Degree in counseling from Naropa University. Major coursework included: Therapeutic relationships, human growth and development, group psychotherapy, Buddhist psychology, family systems, diversity, as well as many others. I also have a Bachelor's degree in Psychology from Western Oregon University.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapist, I will abide by its Code of Ethics. To maintain my license, I am required to participate in annual continuing education and training, as well as other relevant classes dealing with subjects relevant to this profession. As well, I will be in weekly supervision with a colleague of equal or greater licensure and or degree in order to help assist with the process of psychotherapy. Information regarding supervision can be provided verbally in session per request.

Clients/patients are entitled to receive information about the methods of therapy: the techniques used, the duration of therapy (if it can be determined), and the fee structure. Please ask to receive this information. Clients/patients are encouraged to discuss the progress in treatment and have the right to end treatment at any time. Clients/patients may also seek a second opinion. My fees are $100-150 per session and can also calculated per income level or sliding scale in some situations. Payment is due at service unless otherwise specified. If there is insurance or any other funding source, signing this form gives Miles Salisbury permission to communicate with that insurance company or other funding source.
In a professional relationship sexual intimacy between a therapist and client/patient is never appropriate. If sexual intimacy occurs it should be reported to the Grievance board at (503) 378-5499.

Generally speaking, the information a client/patient provides during therapy sessions is legally confidential. The therapist is not permitted to disclose legally confidential information about a client/patient without client/patient consent. There are a limited number of exceptions such as intent to harm others or yourself, or actual or suspected neglect or abuse of children. In couples, marriage and family counseling, the therapist holds a "no secrets" policy. All members of the couple or family system are treated equally and the therapist does not keep "secrets". There may be other exceptions. Confidentiality cannot be assured for electronic communications such as email, cell phones, and facsimile transmissions. Further, these communications can be altered. The client/patient agrees to not hold Miles Salisbury liable or responsible for any breach of communication should the client/patient choose to communicate by electronic means. The client/patient agrees to keep confidential any information discussed during group sessions. The client/patient agrees to not hold Miles Salisbury liable or responsible for any breach of confidentially by group members.

As a client/patient of an Oregon licensee you have the following rights: To expect that a licensee has met the minimal qualifications of training and experience required by state law. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee. To obtain a copy of the Code of Ethics. To report to the Board. To be informed of professional services prior to receiving services. To be assured confidentiality while receiving services as defined by rule and law, including the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to client/patient or others; 3) Reporting information required in court proceedings or by client/patient's insurance company, or relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by a client/patient against a licensee. To be free from being the object of discrimination on the basis or race, religion, gender, or other unlawful category while receiving services. Miles Salisbury, PhD, LPC provides non-emergency psychotherapeutic services by scheduled appointment. In the case of emergency, please call 911 or check into the nearest hospital or emergency room.

I have read the proceeding information and understand my rights as a client. By signing below, I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor or children that I am requesting psychotherapy services from Miles Salisbury, PhD, LPC

_____ _____

Client/Patient signature and printed name Date

_____ _____

Miles Graham Salisbury, PhD, LPC Date