

Grace Duarte de Baker, LCSW

Licensed Clinical Social Worker
Psychotherapy for Adults, Children, Couples and Families.
CA 74511 TN 6737
Serving California and Tennessee
(901) 245-2922

Welcome to my practice!

Please complete the following information so that we can serve you better.

We will be happy to review the practice policies with you and answer any questions you may have.

Carefully review the practice policies and sign consent for treatment at the end.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Gender _____

Which do you prefer? Home Phone Cell Phone Can
we leave a message? No Yes

Married

Single

In a relationship

Children? No

Yes

What is the primary concern or problem that brings you to seek help?

What makes it better? What makes it worse?

What immediate challenges or issues need to be focused on first? Yes/No If yes, please describe:

Have you had counseling or psychotherapy before? Yes/No If yes, dates and with whom?

If yes, what was the previous therapy like? What was helpful? What was not helpful? What did you learn?

What do you want to accomplish in therapy now?

EXPERIENCE – Individual Interior

What are your strengths and weaknesses?

How would you describe your general mood and feelings?

What emotions do you feel more strongly? How do you deal with them?

What are the ways you take care of yourself when you are feeling strong emotions?

How do you respond to stress or problems?

How do you make decisions? (for example, do you use logic and reason or do you trust your gut?)

Do you experience recurring images or thoughts? (either in dreams or awake) Yes/No If yes, describe:

Have you ever attempted to seriously harm or kill yourself or someone else? Yes/No If yes, describe:

Are you *presently* having suicidal thoughts? Yes/No If yes, describe:

Has anyone in your family every attempted to die or died by suicide? Yes/No If yes, describe:

Have there been any serious illness, births, deaths, or other losses or changes in your family that have affected you? Yes/No If yes, describe:

What is your earliest memory? Happiest memory? Most painful memory?

Where do you feel stress in your body (shoulders, neck, back, jaw, etc)?

Do you have ways to express yourself creatively? Yes/No If yes, describe:

Describe your leisure time (hobbies, interests):

Have you ever experience or witnessed verbal, physical, emotional and/or sexual abuse? Yes/No If yes, describe:

In general, how satisfied are you with your life?
Not at all 5 4 3 2 1 Very

In general, how do you feel about yourself (self-esteem)?

Very bad 5 4 3 2 1 Very good

In general how in control do you feel over your life and how you feel?

None at all 5 4 3 2 1 A lot

Please mark any of the following emotions you've had recently or have had in the past.

angry sad
lonely
afraid
anxious/worried
shameful/guilty jealous
happy
grateful/thankful
sexual/erotic excited
energetic
hopeful
relaxed/peaceful

difficulty concentrating
little interest or pleasure in doing things
low or high appetite
excessive tiredness feeling
helpless
having much more energy than normal
thoughts racing through your head
desire to harm yourself
desire to harm someone else
hearing or seeing things that others can't
strange thoughts that are hard to control
fear that someone is trying to harm you
other emotions: _____

BEHAVIOR – Individual Exterior

Are you taking medication? Yes/No If yes, please describe (medication name, dosage, condition)

Do you have a primary care physician? Yes/No If yes, please include name and address.

Have you had a physical in the last year? Yes/No If yes, were there any significant results (diseases, blood pressure)?

Have you ever had a head injury or other serious injury? Yes/No If yes, please describe:

Other medical problems or conditions you have experienced or are experiencing now?

Please mark any of the following behaviors or bodily feelings that are true for you:

drink too much
use illegal or mind-altering drugs
eat too much
eat too little
neglect friends and family neglect
self and own needs
difficulty being kind and loving to yourself
behavior is hurting others lose
your temper
difficulty controlling behavior think
about suicide
difficulty concentrating
Other behaviors: _____

spend more money than you can afford
frequent crying headaches
menstrual problems
dizziness heart
tremors
jitters
sexual preoccupations
tingling/numbness excessive
tiredness blackouts

Do you have any other bodily pains or difficulties? Yes/No If yes, describe:

In general how would you rate your physical health?

Very unhealthy 5 4 3 2 1 Very healthy

Describe your sleeping patterns. (when do you sleep, how many hours? Do you wake up frequently?)

Do you feel rested after sleeping? Yes/No

Describe your eating habits (types of food and how much).

Do you take vitamins or supplements? Yes/No If yes, describe:

Describe your alcohol and drug use. Past and present.

Do you engage in exercise? Yes/No If yes, describe: _____

Do you have any communication difficulties (hearing or speech) Yes/No If yes, describe:

CULTURE – Collective Interior

Describe your relationships with family, friends and coworkers.

What is most important to you? What matters most in your life?

In general, how satisfied are you with your friendships or other relationships?

Not at all 5 4 3 2 1 Very

In general, how comfortable are you in social situations?

Not at all 5 4 3 2 1 Very

Do you think of yourself as spiritual?

Not at all 5 4 3 2 1 Very

Do you have a spiritual or religious belief and/or practice? Yes/No Describe:

In your family of origin, what feelings were you encouraged to express? What feelings were discouraged?

What emotions are most comfortable to you now? What emotions are uncomfortable to you now?

What identities are important to you (gender, ethnicity, politics).

How did your family of origin express love and care? How does your current family express this?

How did your family of origin express disapproval? How does your current family express this?

Describe your current romantic/sexual/love relationships.

Are you satisfied with your sex life? Yes/No Please describe.

What are some of your most important morals? How important are they to you?

Describe any political or civic involvement.

Are you involved in any cultural or environmental activities? Yes/No If yes, describe:

Have you ever experienced prejudice or discrimination (racial, gender, etc) or felt that you were disadvantaged in terms of power and privilege in society? Yes/No Please describe:

SOCIAL SYSTEMS – Collective Exterior

Describe your current physical home environment (house, neighborhood, roommates).

Do you feel that you get along with everyone you live with? Yes/No Describe:

Describe your work environment (include coworkers or supervisors you work with directly).

Have you served in the military? Have you experienced combat? Yes/No If yes, describe:

Are you currently involved in a legal dispute (custody, civil, occupational)?

What parts of your life are stressful?

What support system do you have (friends, family, partner)?

List your family of origin:

Name	Age	Gender	Relationship to you (include step and half)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name	Age	Gender	Relationship to you (include step and half)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your educational background?

What is your occupation? _____

How satisfied are you with the type of work you do?

Not at all 5 4 3 2 1 Very

List your current family or all the people you currently live with.

Name	Age	Gender	Relationship to you (include step and half)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any family history of mental illness? Yes/No If yes, describe:

The following list of various “parts” or aspects of our personality that some people notice within themselves in certain situations, but not in others. Also indicate to the right of the “part”, the situation where you notice this part of yourself.

irresponsible child _____
critical parent _____
dominator/has to be on top _____
prone to fail/”underdog” _____
harsh judge or critic _____ false
or phony self _____ unworthy
or not-good-enough self _____ grandiose/better
than everyone else _____ other – please describe

Is there anything else that you want me to know about?

◆SIGNATURE WITH ACKNOWLEDGEMENT OF INFORMATION◆

With client signature below (signature of parent/guardian if client is under age), this acknowledges that the client (and parent/guardian if underage) has received the following information:

- Therapy services are voluntary, and the client has the right to discontinue when they wish or when it is appropriate. If it is not appropriate to continue treatment, resources that can be helpful will be given to the client, without cost.
- Therapy services with Grace Duarte-Baker, LCSW are confidential except in certain situations that she has reviewed with the client (and parents/guardian if underage).
- Therapy services with Grace Duarte-Baker, LCSW are relatively short-term and includes brief support counseling during periods of crisis if needed.
- In case of immediate life-threatening emergency, the client (and parent/guardian if underage) have been provided information and orientation on how to access these services by Grace Duarte de Baker, LCSW.
- Therapy can include risks and benefits and it is not guaranteed.
- Services of the practice include consultation, evaluation and treatment and there may be different cost for each service, if this is the agreement made with the therapist.
- Services of evaluation include recurrent evaluation sessions to review progress, make changes to treatment and if necessary, to discontinue or continue treatment.
- All therapy and evaluation sessions are typically 50 minutes each but can vary depending on the client's needs.
- Arriving to the scheduled session under the influence of alcohol or drugs, will result in the appointment being canceled. Contact will be made to the emergency contact on file for coordination of client safety if appropriate.
- More than two no-show sessions without calling at least 24 hours ahead, will result in a free referral to alternative services that may be more appropriate to continue your treatment.
- The full cost of services is \$70 per session. Cash, credit or debit cards or secure online payments are accepted.
- Payments for each session must be made after each session. Alternate arrangements can be made.
- Grace Duarte de Baker, LCSW is not part of any health insurance network.

- To cancel or change an appointment, please call or text (901) 245-2922 at least 24 hours before your scheduled appointment.
- Calls to the main practice number (901) 245-2922 are returned within 24 hours.

Attention: Your signature on this form confirms that you have consulted with Grace de Duarte Baker, LCSW to your satisfaction and that you agree to begin and complete evaluation and receive recommendation for treatment services with her.

Please print name of client receiving treatment _____

Client signature : _____ Date _____
(parent signature if client is underage))

Signature and Statement that I have received the Limits of Confidentiality separately.

Client Signature:
(Parent/Guardian if under 18): _____ Date: _____