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Client Information:

Patient Name:		Today's Date:
Home Address:		Date of Birth:
Home Phone:	Cell Phone:	Work Phone:
May I leave a message? Y N		
Email:	Best way to reach you:	
Are you? Married Single Separated Divorced Remarried		
Do you have children? Y N		
If yes, names & ages:		

Emergency Contact Information:

In case of emergency, who should I contact?

Name:	Relationship:
Address:	Phone:

Client History

What brought you in for therapy? Please describe what your current issues are.

How long has the problem been present?

Any current stressors that I should be aware of?

Which of the following have you experienced?

{ } Suicidal Thoughts
{ } Suicide Attempts or a Plan to harm yourself
{ } Substance Abuse/Dependence
{ } Addiction
{ } Recovery Treatment for addiction such as alcohol, drugs, pornography
{ } Depression (sad, down, affecting biological functioning)
{ } High or low energy level
{ } Angry/Irritable
{ } Loss of interest in activities
{ } Difficulty enjoying things
{ } Crying spells
{ } Decreased motivation
{ } Panic Attacks
{ } Shortness of Breath
{ } Trouble sleeping
{ } Withdrawing from others
{ } Negative thinking
{ } Change in weight or eating habits
{ } Mood swings

{ } Self Harm (Cutting)
{ } Thoughts or Plan to harm others
{ } Poor concentration/Difficulty focusing
{ } Feelings of Hopelessness/Worthlessness
{ } Feelings of shame or guilt
{ } Racing Thoughts
{ } Flashbacks/ Nightmares
{ } Sexual Abuse
{ } Anxious, Nervous or Tense
{ } Low Self Esteem
{ } Hearing Voices
{ } Paranoid Thoughts
{ } Perfectionism
{ } Rituals of counting things, or needing things in a certain order
{ } Issues with body image
{ } Eating disorder
{ } Binge eating/ purging
{ } Feeling a loss of control over eating
{ } Job problems
{ } Adoption
{ } Other

Previous Treatment:

Have you been in therapy before? Y N

What did you like/dislike about your previous treatment?

Have you had any hospital stays for psychological concerns: Y N

Date: Reason for stay:

Are you currently experiencing thoughts of harming yourself or someone else?

Y N

Have you in the past experienced thoughts of harming yourself or someone else?

Y N

Developmental History:

Are you aware of any difficulties or complications during the time your mother was pregnant with you? Y N

If yes, explain:

Did you walk, talk and read at appropriate developmental milestones?

Any learning delays, trouble in school?

Medical History:

Primary Care Physician: Name_____ Phone_____

Address:_____

How would you rate your current physical health?

When was your last physical?_____

Any health concerns that are impacting your mental health?

_____

Do you exercise regularly? Y N

List any current or important past medications:

Medication and Dose:	Response to medication:
_____	_____
_____	_____
_____	_____
_____	_____

History of serious childhood illness: Y N

If yes, please describe:

Other health concerns, serious illnesses, conditions or major operations requiring hospitalization?

Have you experienced a head injury? Y N

Did you lose consciousness? Y N

If you are a <u>woman</u>, have you had any of the following?

Pregnancies to term	Y	N	Terminated pregnancies	Y	N
Miscarriages	Y	N	Still births	Y	N

Family History:

Birth location:

Raised by: { } Mother { } Father { } Step-Mother { } Step-Father { } Grandparents { } Other

Briefly describe your relationship with your parental figures:

_____

_____

_____

_____

Do you have siblings? Y N

First names:

Ages:

Describe your relationship with them:

Any history of neglect? Physical Abuse? Verbal, Emotional, Spiritual Abuse?

Sexual Abuse? Any family history of substance abuse?

Any family history of mental illness (including depression, anxiety}?

Any family history of suicide?

Any history of domestic violence?

Any additional family information?

Social History:

Describe your relationship with peers and/or friends?

How would you describe your social support?

Any history of being bullied?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History:

What is the highest educational level you have completed?

When attending school where you:

{ } In regular classes { } Home study { } Advanced classes { } Ever suspended

{ } Have an IEP or special accommodation { } Placed in an alternative school

Did you have a learning delay? Y N

Was it diagnosed? If so, what was it?

Any history of ADHD? Y N

Any additional information that you think would be important to know:

Occupational History:

What is your current employment status?

{ } Employed Full Time { } Employed Part Time

{ } Unemployed { } Self Employed

{ } Student

If you are employed, Name:_____

Address:_____

Are you satisfied with your employment?

If not, why?

Any issues at work that would be helpful to know?

Marital History:

Are you currently?

{ } Married { } Never Married { } Separated { } Divorced { } Widowed

If Married:

Spouse's Name: _____ # Years married: _____

Please briefly describe the nature of your marital relationship:

How would you rate your marriage?

{ } Poor { } Fair { } Good { } Great

Please list any previous marriages/significant relationships (include name and duration):

Marital History Continued:

Do you have any children? Y N

If yes, complete the following:

First Name	Age	Gender

Are there any medical, behavioral, educational, social issues currently involving your children?

Are there presently any child custody issues involving you or your family?

Does your family currently have Child Protective Services involvement? Y N

If yes, why is CPS involved?

If yes, please complete the following:

Case Workers Name: _____ Phone: _____

Substance Use History:

Do you drink alcohol? Y N

If yes, how often: Daily Weekly Monthly

Are you currently or have you ever used any of the following substances?

Alcohol Tobacco Marijuana Caffeine Cocaine or Crack

Heroine Amphetamines Hallucinogens Pain Medications

Club Drugs Benzodiazepines Other (please List)_____

If you circled any of the above, please complete the following substance use history chart.

Substance Age of 1st use Frequency of use Amount Used

_____

_____

_____

Please complete the following chart if you have received treatment for a substance abuse issue:

Name of Treatment Program	Type of Treatment (in –patient, rehab, outpatient, hospitalization)	Date of Treatment (Month, Year)
Outcome:		

Legal History:

Do you have any pending criminal charges? Y N

Are you on probation? Y N

Have you ever been convicted of a crime? Y N

If you answered yes to any of the above questions, please provide details, including date, type of conviction, outcome_____

_____

Additional Information:

What are your goals for therapy?

What expectations do you have for therapy?

What are your strengths?

What are some areas of growth?

Signature of client_____ Date_____

Welcome to my practice. First of all, I want to commend you for taking the first steps toward hope and healing. The therapeutic process can provide such freedom. This document contains important legal and ethical information about my professional services and it is important that you take the time to read and understand it.

The therapeutic relationship is vital to the success of your therapy. Therapy works in part because of the clearly defined rights and responsibilities held by each person. As a client, you have certain rights. There are also legal limitations to those rights that you should be aware of.

Goals of Counseling:

There can be many goals for the counseling relationship. And these goals can change or evolve as therapy moves forward. Some of these goals can be long term such as improving the quality of life, learning to live with mindfulness, recovery, or restored relationships. Others may be more immediate goals such as decreasing anxiety, symptom relief, changing a behavior, or increasing social support. Whatever the goals for therapy, they will be set by the client according to what they want to work on during their sessions. This is your journey and while I am there as a guide and support, it is imperative that you embrace the desire to change and do the work necessary to move towards your goals. I may make suggestions, but ultimately, the goals are yours and the time in therapy is yours.

Risks/Benefits of Counseling:

Counseling is an intensely personal process. If you choose to enter into the journey, it can bring up painful memories, hurtful experiences or even reintroduce certain traumas into your thinking. There are no guarantees that therapy will work for you. Clients can make progress then return to old patterns of behaving. Progress may happen slowly. Counseling requires a very active effort on your part. In order to get the most out of therapy you will need to work on things, do the homework, engage in reflection outside of our sessions.

There are several benefits to therapy. Counseling can help you develop essential life skills, reduce symptoms of mental health issues, improve the quality of your life and relationships, develop healthy styles of relating, communicate more effectively, take better care of yourself, grow in knowledge, have more useful coping skills and develop confidence in who you were meant to be.

Confidentiality:

Trust is at the heart of the therapeutic relationship. For this reason, every effort will be made to keep your personal information private. If you wish to have your information released we will discuss whether that is in your best interests, and you will be required to sign a consent form before such information is released to anyone. Safety is also at the heart of therapy. I have a legal and ethical responsibility to you and the community. Because of this, there are some limitations to confidentiality. I may consult with colleagues on your case to offer you the best possible help. In the even that I speak with another therapist, no identifying information such as your name will be released. Therapists are required by law to release information when the client poses a risk to themselves or others. As well I am a mandated reporter if there are any issues of child or elder abuse. If I am subpoenaed, I may be required by law to release information, but I would consult with other professionals and limit the release to only what is necessary by law. In keeping with the laws surrounding confidentiality, I also wanted to mention that if by chance, we should randomly see one another out in the community, I will not initiate a greeting. If you however were to recognize and greet me, I would respond appropriately, keeping in mind that anything you may want to share should be done in session.

Appointments:

Appointments will be 50-60 minutes. We will decide together how often you would like to be seen. The time scheduled for you is designated for you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you will be responsible to pay for your session. I understand that circumstances do arise that are out of your control. If this is the case, you will not be responsible for the fee. In addition, you are responsible for coming to your appointment on time. If you are late, your appointment will still need to end on time.

Fee Schedule:

Appointment Fee	Income
$150	$80,000 plus
$125	$60,000-$80,000
$100	$40,000-$60,000
$75	Less than $40,000
$60	Full-Time College Students and/or Veterans

You are responsible for paying at the time of your session unless prior arrangements have been made. Fees are not negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at the therapist's discretion.

Confidentiality and Technology:

As your therapist I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communication will not occur. If you prefer to communicate via email or telephone to arrange things like appointments or updates, please be advised of any friends, family or significant others who may have access to your phone or computer.

Contacting Me:

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message on my confidential voicemail and I will get back to you as soon as possible, but it may take a day or two for non-urgent matters. If you call on a Friday, I will return your call on Monday as I do not work on the weekends. If your call is urgent and you feel you cannot wait for a return call or it is an emergency, please go to your local hospital or call 911.

Client
Signature_____Date_____