Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome! I look forward to our work together as you seek to make positive, healthy changes in your life. Taking this first step toward new personal growth, like any new situation, can be both exciting and anxiety provoking, in part because you do not know what to expect. I want to make your experience with me as comfortable and productive as possible. Therefore, in an effort to provide you with important information about our work together, and to promote a trusting and well-informed therapy relationship, I have constructed this document, which outlines crucial elements of the therapy experience as well as information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them together. This document will represent our professional agreement with one another.

**PSYCHOLOGICAL SERVICES:**

Psychotherapy is not easily described in general statements. It is an active and cooperative effort involving both the client and the therapist. Psychotherapy has both benefits and risks. For instance, therapy may result in reduction in feelings of distress, increased coping skills, solutions to specific problems, positive behavioral changes, more satisfying relationships, etc. At the same time, since therapy often involves discussing aspects of your life that you are currently struggling with, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and/or helplessness in the process.

Throughout our work together, I will be committed to providing you with the highest level of professional care that I am capable of. This will likely include facilitation of self-awareness, encouragement of new insights, experimentation with new behaviors, and new ways of looking at yourself and your life circumstances.

Change usually involves letting go of things that are familiar in order to make room for new possibilities to emerge. Also, changes that you make in one area of your life (e.g. your interpersonal style) may induce changes in other areas (e.g. your relationships with others). All in all, there are no guarantees of what you will experience.

Our first contact may consist of a free phone consultation during which you and I will make an initial determination about whether or not we believe my services are a good fit for you. If we decide to proceed from there, the following 1-2 sessions will be considered an initial assessment period, which may include one or more of the following: an evaluation of existing current distress, a discussion of the factors that are contributing to your current concerns, and a complete psychological history. At any time during these contacts, and no later than the end of the second session, I will discuss with you whether or not I believe that you could benefit from my services, or if other services/care providers would be best suited to meet your needs. If we both determine that you could potentially benefit from my services, I will offer you some initial impressions of what our work together would include and recommend a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with me to decide if you wish to continue the recommended course of treatment. If at any point during the course of therapy, if either the therapist or the client decides that other treatment alternatives are a better fit, I will provide you with referrals for alternative treatment services. Also, I may determine that supplemental treatment recommendations (e.g. psychotropic medications, reduction or cessation of drug/alcohol use, 12-step programs, a medical evaluation, etc.) would strongly support or be required for your continued use of my services. In some situations, my willingness to provide services will be dependent upon your participation in these additional treatment recommendations.

* *Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**TELEHEALTH:**

In order to best serve all of our clients we have incorporated TELEHEALTH services available by using Doxy.Me which is a HIPPA compliant platform, or Zoom platform to allow counseling services to continue from the comfort of your home if you so choose. If this is the method you would like to do therapy please indicate this to me and we will talk about the benefits and the challenges that at times can occur.

* *Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**APPOINTMENTS:**

An appointment (or session) is scheduled for 50 minute duration. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. If you arrive late for your appointment, the session will still end on time, and will not run into the next person’s appointment. In order to be seen in the case of late arrivals, you will still need to pay the full fee, even if you will only be seen for a portion of the session. Since I am paid according to my time, it is difficult for me to continue working with clients who exhibit irregular attendance and/or lack of contact regarding missed appointments. Therefore, I may terminate your therapy if you develop a pattern of canceling late and/or not showing for appointments.

* *Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**CANCELLATIONS:**

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours’ notice is required for re-scheduling or canceling an appointment. If you know in advance that you will have a time conflict with a scheduled appointment, please let me know as soon as possible, and I will try to find another time to reschedule the appointment. In the event that you do not cancel an appointment 24 hours in advance, you will be charged $35 for the missed appointment. This amount will be due at the time of your next scheduled appointment. *\* Client’s Initials \_\_\_\_\_\_\_\_*

**PROFESSIONAL FEES AND PAYMENT:**

As mentioned previously, I will provide a free phone consultation to anyone who is interested in learning more about my services and to provide an initial determination about whether or not my services are appropriate for you. Thereafter, my fee for each 50 minute counseling session will be determined before the first session. What this means is we will discuss the cost of service at the initial contact over the phone or through email. I never want the cost to get in the way of providing quality service to my clients so I will work with you to meet your needs on an individual basis.

My fee for group counseling varies depending on the type of group and the length of the group sessions. A separate informed consent form will be provided for participation in all group counseling.

All charges are payable by cash, check; I do take credit/debit cards using Ivy Pay Merchant services. At this time, I am not a member of any managed care/insurance provider panels.

*\* Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**CONFIDENTIALITY:**

In general, the privacy of all communications between a patient and mental health counselor is protected by law, and I can only release information about our work to others with your written permission. But there are some situations in which I may be legally obligated to reveal some information about a client, even without consent:

* If a client threatens serious bodily harm or death to himself/herself.
* If a client threatens serious bodily harm or death to another.
* If the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples include: violence toward a minor, a minor witnessing violence or being in the presence of violence, drug use in the presence of a minor or while caring for a minor, financial exploitation of an elder adult, etc. This also includes incidents of past abuse, including those mentioned above, in any minor is still present

in the home and/or the alleged perpetrator of abuse is currently in a caretaker capacity with any minor(s).

* If a client is involved in a legal proceeding and a judge issues a court order for my testimony.
* If a client pursues civil or criminal legal action against me or if a client makes a complaint to a Professional Board about me.
* If release of information is otherwise required by law (e.g. reporting of medical errors, court order, the Patriot Act).

*\*Client’s Initials\_\_\_\_\_\_\_\_*

**CONTACTING ME:**

Due to the nature of my work, it is important that I clarify that I am often unavailable to take calls or return calls immediately. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call on the day you make it or by the next business day following the day you make the call, with the exception of Sundays and holidays. I do not check voicemail before 10 am or after 6pm, during weekdays. In all cases of emergency, call 911 or the Crisis Hotline (211) immediately or go to the nearest hospital emergency room. If I will be unavailable for an extended time, I will discuss this with you ahead of time, and if you are interested, provide you with the name of a colleague to contact, if necessary. I use text messaging for appointment scheduling only. Text messaging will only be used with your consent.

*\* Client’s Initials \_\_\_\_\_\_\_\_\_*

**DUAL RELATIONSHIPS:**

Although our sessions may be very intimate psychologically, it is important that you be assured that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with me. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. I will never acknowledge working with anyone without their written permission.

*\*Client’s Initials\_\_\_\_\_\_\_\_\_\_\_*

**SOCIAL NETWORKING AND INTERNET SEARCHES:**

I do not accept friend requests from current or former clients on social or business networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

 *\* Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**E–MAILS, CELL PHONES, COMPUTERS, AND FAXES:**

It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on my laptop is encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. My laptop is equipped with a firewall, a virus protection and a password. Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

*\* Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**TERMINATION**:

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with myself. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

*\* Client’s Initials \_\_\_\_\_\_\_\_\_\_*

**SIGNATURES:**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HAVE READ AND HAVE A COPY OF THE “NOTICE OF PRIVACY POLICY”**

\**Client’s Initials* \_\_\_\_\_\_\_\_\_

# General Health Information

Please fill out this Intake form as completely as possible. It will help me in our work together. ***Information is confidential as outlined in HIPAA Notice of Privacy Practices.*** If you do not desire to answer any question, merely write, "NA." Please print or write clearly and bring it with you to the first session.

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name you prefer to be called if different: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Gender:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fill in below the number(s) at which we may call you (Please note that cell phones may not be secure):

Cell: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ May we leave a message? Yes No

**Do you want to get your appointment reminder by text message?** Yes No

**\*Please note text messaging and email are not secure methods of contact or HIPPA compliant**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (street address) (city) (zip)

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your current relationship status (Please check all that apply):

 Single In a Relationship Living with Partner Married Separated Divorced

Widowed

Please indicate your racial/ethnic background (if desired): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly describe the concerns for which you are seeking services: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how long have you had the current problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had this (or a similar) problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate the intensity of the problem or concern that brought you in? (circle number)

 1 (not very intense) 2 3 4 5 6 (extremely intense)

How much has your current problem interfered with your ability to function socially/academically/work?

1 (not at all) 2 3 4 5 6 (extensively)

**What are your goals for counseling?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel motivated to work on your goals? Yes No I’m not sure yet

Have you received counseling here or elsewhere before?  Yes  No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_

What was the focus of this treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeking therapy services elsewhere? Yes No

Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the focus of this treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a psychiatrist/have you seen a psychiatrist in that past? Yes No

If yes, with whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What psychiatric medications are you taking now? n/a Names/dosages of medications: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever been hospitalized for psychological reasons? Yes No

How many times have you been hospitalized? \_\_\_\_\_\_ Approximate Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL members of your family (including parents, step-parents, spouses/partners, and children) and their ages. Also, list anyone whom you believe had/has an emotional, mental, alcohol or drug abuse problem (e.g. alcoholism, abuse, depression, anxiety, eating disorder, poor communication, psychiatric hospitalization, etc.)

Family Member (e.g. mother) Age Emotional, mental, alcohol or drug abuse problem

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

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

Have you ever intentionally inflicted any harm upon yourself? Yes No

What kind of self -harm?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? Yes No

How often are you having suicidal thoughts presently?

 Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past?  Frequently Sometimes Rarely Never

Are you having thoughts of harming others presently?

 Frequently Sometimes Rarely Never

How often have you had thoughts of harming others in the past?

 Frequently Sometimes Rarely Never

How often do you drink alcohol? Never 1-2 times/week 3-5 days/ week Daily A few times a month Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Think back over the last two weeks: have you had five or more drinks\* at a sitting? Yes No

\*A drink is a 12oz bottle of beer, a 5oz glass of wine, a 12oz wine cooler, a shot of liquor, or a mixed drink\*

On average, how many drinks do you typically have when you do drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or does someone else think that you may need to cut down or stop drinking alcohol?

 Yes No Maybe

How often do you use other drugs, **this will be kept confidential** (marijuana, cocaine, ecstasy, etc)?

Never 1-2 times/week 3-5 days/ week Daily A few times a month

Please list drugs used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or does someone else think that you may need to cut down or stop using other drugs?

 Yes No Maybe

The following has resulted from my alcohol/drug use: n/a Traffic violation

 Vomiting Discord in relationship Fight with friend Academic/work problems

 Difficulties with memory Other; please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced legal problems?  Yes No  Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times a week do you exercise?

 Never 1-2 times a week 3-5 days a week Daily Rarely

Are you ***currently*** having any difficulty with appetite or eating habits? Yes No (If applicable): Eating less Eating more Bingeing/ Purging/Vomiting Significant weight change (last 2 months)

 In the ***past***, have you tried to control your weight by (Please check all that apply):  N/A

 Not eating Vomiting Laxatives Diuretics Diet pills Exercise Calorie counting

 Food rituals Other; Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ***currently*** trying to control your weight by (Please check all that apply):  N/A

 Not eating Vomiting Laxatives Diuretics Diet pills Exercise Calorie counting

 Food rituals Other; Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your physical health at present?

 Unsatisfactory Below Average Average Above Average Excellent

Do you have any known medical problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking any prescribed medication other than the psychiatric medications mentioned above?

 Yes No Please indicate all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any problems with your sleep habits? Yes No Sometimes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(circle all applicable): Sleeping too little Sleeping too much Poor quality sleep Trouble falling asleep

 Frequent awakening Disturbing dreams Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how many significant romantic relationships have you had? \_\_\_\_\_\_

Are you in one now? Yes No

Do you have any problems or worries about sexual functioning?  Yes  No

 Lack of desire Sexual Impulsiveness Difficulties maintaining arousal Worried about STDs

How would you rate the quality of your past romantic relationships?

 Very Poor Unsatisfactory About Average Good Excellent N/A

How would you rate the quality of your current romantic relationship?

 Very Poor Unsatisfactory About Average Good Excellent N/A

When was your first sexual experience? \_\_\_\_\_\_\_\_\_\_ Was it Consensual? Yes No N/A

***As a CHILD*** (under 18) have you ever been a victim of:

 Emotional abuse Physical Sexual abuse as a child (*including touching/viewing*) None

 If yes, did you receive counseling? Yes No How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you work through it? Yes No Not sure/still affects my life

***As an ADULT*,** have you ever been a victim of:

 Emotional abuse Physical Sexual abuse None

*\*\*This could be from a boyfriend/girlfriend/partner/stranger/family member/etc.*

 If yes, did you receive counseling? Yes No How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you work through it? Yes No Not sure/still affects my life

Has this played a large role in your life in your personal and romantic relationships or interactions with other men/women? Yes No N/A

Do you experience flashbacks or nightmares from these experiences? Yes No N/A

How happy or adjusted were you growing up?

 Not at all Slightly About average Substantially Completely

Did you experience learning problems in elementary, middle, or high school?

None Little Some Substantial Lots, constant struggle

Did you experience social adjustment problems in elementary, middle, or high school?

 None Little Some Substantial Lots, constant struggle

Did you get bullied?

 Never Sometimes All the time

If you did get bullied, does the issue still affect your view of life, yourself, or your behaviors? Yes No N/A

How would you rate the quality of your current friendships?

Very Poor Unsatisfactory About Average Good Excellent

How much is your immediate family a source of emotional support for you?

Very little or none Little Somewhat Substantial

Overall, how many people can you count on right now for friendship or emotional support? \_\_\_\_\_\_\_\_\_\_\_

Who is your PRIMARY source of emotional support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to this office: Self Parent Spouse Google Search/Search Engine

 Physician Psychologytoday.com Goodtherapy.com

 Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Advertisement: Please specify where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I verify that the above information is accurate to the best of my knowledge.

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

Client Printed Name Client Signature Date

Directions: Please indicate the degree to which each of these has been a problem/concern in the **past 2 weeks**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | None  | Little  | Moderate  |  Significant  |
| Depression, low mood, sadness, crying  |    |    |    |    |
| Trouble sleeping (too little/much, insomnia, nightmares)   |    |    |    |    |
| School/Career problems  |    |    |    |    |
| I can get aggressive or violent with others |    |    |    |    |
| Attention, concentration, distractibility  |    |    |    |    |
| Low energy/fatigue/frequently tired   |    |    |    |    |
| ***Thoughts*** of ending my life   |    |    |    |    |
| ***Plans*** to end my life  |    |    |    |    |
| Thoughts or plans of harming others, including animals   |    |    |    |    |
| Porn or other addictions that affect the quality of my life   |    |    |    |    |
| Spiritual, religious, moral, ethical issues  |    |    |    |    |
| Difficulties with trust  |    |    |    |    |
| Obsessions, compulsions (thoughts or actions that repeat themselves)  |    |    |    |    |
| Anxiety/Panic attacks   |    |    |    |    |
| Eating problems (overeating, undereating, appetite, vomiting)  |    |    |    |    |
| Co-dependency (how you feel depends on how others feel)  |    |    |    |    |
| I feel anxious more often than not |    |    |    |    |
| Sexual issues, dysfunctions, conflicts, desire differences  |    |    |    |    |
| Mood Swings   |    |    |    |    |
| Do not like my body   |    |    |    |    |
| Question my sexual identity/orientation   |    |    |    |    |
| Anger, hostility, arguing, irritability  |    |    |    |    |
| I have a hard time dealing with stress  |   |   |   |   |
| I see, hear, smell, or feel things that other people do not  |   |   |   |   |
| I can get paranoid about certain things |   |   |   |   |
| I feel guilty a lot of times, even when it’s not my fault  |   |   |   |   |
| Low Self-Esteem  |   |   |   |   |
| Alcohol Use  |   |   |   |   |
| Drug use (including prescription & over-the-counter) |   |   |   |   |
| Fears/Phobias that affect the quality of my life  |   |   |   |   |
| Grieving, mourning, deaths, losses, divorce  |   |   |   |   |
| Impulsiveness, loss of control, outbursts  |   |   |   |   |
| Marital/Partner/Relationship Conflict  |   |   |   |   |