Oc Counseling

Jenna Free, M.S., Registered Associate MFT, AMFT #106836 ● (262) 442-4803
Supervised by: Joseph P. Jardine, M.S., LMFT, MFC#47657 ● (949) 292-7833
Joseph Jardine Child and Family Therapy, Inc.
Jenna's Offices: 2522 Chambers Rd., Suite 100 · Tustin
26040 Acero · Mission Viejo

*Name*_____ *Date*_____

Street_____City_____State_____Zip_____

Home Ph ( )_____ *Work* Ph ( )_____*Cell* Ph ( )_____

Referred By: _____

The fee for counseling services is $ 165 per 45-minute session. This is to be rendered at time of service. Twenty-four hour (24) cancellation is required to avoid being charged for the scheduled appointment. The purpose of our initial consultation is to determine your needs and to help you decide what form(s) of psychological consultation may be desirable and most beneficial for you. Please read over and sign the Informed Consent form provided to you. Please feel free to ask any questions if something seems unclear or not completely understood.

Reason for seeking consultation: _____

_____

_____

I agree to submit any disagreement regarding services or complaints regarding breaches in law or ethics to binding arbitration under the auspices of the American Arbitration Association located in Irvine, CA. I further agree to pay any and all legal costs arising from complaints that are not fully validated by the arbitrator.

_____ _____
Signature *Date*

OFFICE POLICIES & GENERAL INFORMATION

AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Joseph P. Jardine (which refers to himself and any staff practicing under his supervision). In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Joseph P. Jardine will use his clinical judgment when revealing such information. Joseph P. Jardine will not release records to any outside party unless he is authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination, where Joseph P. Jardine becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the police, hospital or the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Joseph P. Jardine and staff, only the minimum necessary information will be communicated to the carrier. Unless authorize by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Joseph Jardine has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies. computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies. computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone (also cordless phones) communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify Joseph P. Jardine at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes in emergency situations.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Joseph P. Jardine to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.
Consultation: Joseph P. Jardine consults regularly with other professionals regarding his/her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.
* Considering all of the above exclusions, if it is still appropriate, upon your request, Joseph P. Jardine will release information to any agency/person you specify unless Joseph P. Jardine concludes that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Jenna Free between sessions, please leave a message on the answering machine 262-442-4803 and your call will be returned as soon as possible. Jenna checks her messages a few times a day (but never during the night time), unless she is out of town. Jenna checks the messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call 714 834-6900 a 24-hour crisis line, or your local police department by dialing 911.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $_165_ per 45-minute session at the end of each session or at the end of the month unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify Joseph P. Jardine if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, Joseph P. Jardine will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Insurance companies reimburse not all issues/conditions/problems, which are the focus of psychotherapy. It is your responsibility to verify the specifics of your coverage.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Joseph P. Jardine and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Orange County, CA in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Joseph P. Jardine can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys. fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Joseph P. Jardine will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Joseph P. Jardine may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Joseph P. Jardine is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), and psycho-educational.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, Joseph P. Jardine will discuss with you (client) his working understanding of the problem, treatment plan, therapeutic objectives, and his view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Joseph P. Jardine expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Joseph P. Jardine does not provide, he has an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, Joseph P. Jardine will assess if he can be of benefit to you Joseph P. Jardine does not accept clients who, in his opinion, he cannot help. In such a case, he will give you a number of referrals that you can contact. If at any point during psychotherapy, Joseph P. Jardine assesses that he is not effective in helping you reach the therapeutic goals, he is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, he would give you a number of referrals that may be of help to you. If you request it and authorize it in writing Joseph P. Jardine will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Joseph P. Jardine will assist you in finding someone qualified, and, if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Joseph P. Jardine will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Joseph P. Jardine's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Joseph P. Jardine will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Orange is a small community and many clients know each other and Joseph P. Jardine from the community. Consequently, you may bump into someone you know in the waiting room or into Joseph P. Jardine out in the community. Joseph P. Jardine will never acknowledge working therapeutically with anyone without his/her written permission.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of **24 hours (1 day) notice is required** for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

_____

Client name (print) Date Signature

_____

Therapist Date Signature

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided

to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:
1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Joseph Jardine; 949.292.7833

VII. EFFECTIVE DATE OF THIS NOIICE
This notice went into effect on April 14, 2003.
I acknowledge receipt of this notice

Patient Name: _____ Date: _____

Signature: _____

(Please fill out for minors)

CONCERNING MINORS and CONFIDENTIALITY

Parents have responsibility for their children. Generally, when their children are in treatment, the parents are the holder of privilege and have the rights to information relevant to their child's health and welfare. Parental control is widely held up by the law. Though this is true, minors are also recognized as having rights to confidentiality, even though parents usually control those rights. Parents, not minors, have the right to waive confidentiality.

Like any other client, minors need to feel safe in a therapeutic relationship. The best approach a parent can take in regards to this situation would be to allow their child freedom to disclose events in their life without fear of reprisal from their parent or legal guardian. This obviously would be limited in the event that a child's health and general welfare are threatened. Parents have rights to information about the health and welfare of their child. However, a counselor cannot share with the parents any information, which places the child at risk of harm.

The older the minor is, the greater their need for privacy becomes. An adolescent's desire for maintaining confidence of disclosed information is extremely high. This is an important factor in effective treatment, because the trust level and rapport are foundational if change is to occur.

In rare and under certain circumstances, a minor can be seen in treatment without parental consent. The minor must be 12 years of age or older and:

1. Seek treatment for issues related to drug or alcohol problems.
2. Seek treatment for issues related to child abuse.
3. Would present a danger of serious harm to him/herself, or others, without treatment.
4. Seek treatment for issues related to sexual assault (such as rape or incest).
5. Pregnancy counseling.

A counselor or psychologist can break confidentiality without consent when the client is under 16 years of age and has been the victim of a crime, and if disclosure is considered to be in the best interest of the minor.

Please take moment to review this information, and then sign below. This will verify you have read this information and are aware of these conditions and terms regarding minors and the limits of confidentiality. Thank you.

_____ _____

Signature Date

Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

This card will be used to pay for the full fee of the session.

In case of late cancellations (within 24 hours) and/or no-shows for scheduled sessions, you will be charged the full session fee as well.

I, _____(print name), am authorizing Joseph Jardine Family and Child Therapy, Inc. the use of my credit card/FSA/HSA in the event that I do not cancel my appointment at least 24 hours in advance as agreed to in the Informed Consent.

Card Type (circle one): Visa Master Card Discover FSA HSA
Card #: _____
Expiration Date:_____ Zip Code _____
Name as Printed on Card:_____
Verification/Security Code (3-digit code on back by signature line):_____

BIOGRAPHICAL INFORMATION - INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: H: _____ W: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON AND PHONE NO. TO CALL IN EMERGENCY:
Name _____ Phone _____ Relationship _____

REFERRAL SOURCE: _____

OCCUPATION (former, if retired): _____

PRESENTING PROBLEM (be specific: when did it start, how does it affect you, etc.):
_____
_____
_____

Estimate the severity of the above problem: Mild__, Moderate__, Severe ___, Very severe __

Do you have any sleeping disturbances or appetite changes? Yes _____ No _____
If so, please explain: _____
_____

Why did you decide to seek help now? _____
_____

What is your goal in coming here? _____
_____

What would be a sign that you are getting on track? _____
_____

What specifically do you want to change about yourself? _____
_____

CURRENT: Marital status: ___ Live with someone: ___ Name: _____ Years: ___

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1._____
2._____
3._____
4._____
5._____
6._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

Mother:_____

_____

_____

Step-parents_____

_____

_____

IF PARENTS DIVORCED: Your age at time: _____, Describe how it affected you then/now:

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____
2._____
3._____
4._____
5._____

MEDICAL DOCTOR/S (name /phone):

1. _____
2. _____
3. _____

PAST/PRESENT MEDICAL CARE (major medical problems, hospitalizations, surgeries, accidents, falls, illness):

_____
_____
_____
_____

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

_____
_____
_____

SEXUALITY – Are you currently sexually active? Yes ____ No _____

Do you feel any part of your sexuality is unhealthy or out of control? _____
_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (Current consumption patterns, list any AA, NA, treatments):

_____
_____
_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

_____
_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc.): _____
_____
_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____
_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____
_____
_____
_____
_____

Who do you currently use for social/emotional support?

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

_____

_____

2. _____

_____

_____

3. PLEASE ADD PAGES OR MORE INFORMATION ABOUT PSYCHOTHERAPISTS.

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

_____

CHECK ALL THAT APPLY TO YOUR CHILDHOOD:

□ Nightmares	□ Abuse	□ Fears	□ Bed Wetting
□ Thumb sucking	□ Rebellion	□ Stammering/Stuttering	□ Sexual Molestation
□ Happy Childhood	□ School Problems	□ Memory Blanks	□ Sleep-walking
□ Unhappy Childhood	□ Allergies	□ Learning Difficulties	□ Social Difficulties

Describe traumas or losses in your life: _____

_____

_____

How would you describe your general personality style? _____

_____

_____

What gives you the most joy or pleasure in your life? _____

_____

_____

What are your main worries and fears? _____

_____

_____

What are your most important hopes or dreams? _____

_____

_____

(Please fill out for couples)

ADDTITIONAL INFORMATION FOR COUPLES ONLY

PARTNER NAME: _____ PARTNER NAME: _____

CURRENT STATUS:

□ Married	□ Dating
□ Separated	□ Cohabitating
□ Divorced	□ Living Apart

LENGTH OF RELATIONSHIP: _____

PRESENTING PROBLEM (be specific: when did it start, how does it affect you, etc.):

_____
_____
_____

Estimate the severity of the above problem: Mild__, Moderate__, Severe ___, Very severe __

What have you already done to deal with the difficulties? _____
_____
_____

Make at least one suggestion of what you could do personally to improve the relationship regardless of your partner's actions: _____

On a scale of 1-10 (with 10 being extremely happy), what is your current rate of happiness that you feeling in the relationship.

Partner Name: _____ Rating: _____
Partner Name: _____ Rating: _____

What are your biggest strengths as a couple? _____
_____
_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):
1. _____
_____
2. _____
_____
3. PLEASE ADD PAGES OR MORE INFORMATION ABOUT PSYCHOTHERAPISTS.

FOR THE FOLLOWING, PLEASE CHECK ALL THAT APPLY:

Have either you or your partner ever struck, physically restrained, used violence against, or injured the other person?
Yes: _____ No: _____ Myself: _____ My Partner: _____ Both of Us: _____

If yes, please explain the circumstances and frequency: _____
_____
_____

Do either you or your partner perceive to have withdrawn from the relationship?
Yes: _____ No: _____ Myself: _____ My Partner: _____ Both of Us: _____

Do with you or your partner feel your relationship satisfaction has diminished over time?
Yes: _____ No: _____ Myself: _____ My Partner: _____ Both of Us: _____

If yes, please explain any significant events contributing to this: _____
_____
_____

Have either you or your partner threated to separate or divorce (if applicable) due to the current presenting problem?
Yes: _____ No: _____ Myself: _____ My Partner: _____ Both of Us: _____

Have either you or your partner consulted with a lawyer about divorce (if applicable)?
Yes: _____ No: _____ Myself: _____ My Partner: _____ Both of Us: _____

How frequently have you had sexual relations during the past month? _____ times.

On a scale of 1-10 (with 10 being extremely satisfied), what is your current rate of satisfaction with the frequency of your sexual relations?

Partner Name: _____ Rating: _____
Partner Name: _____ Rating: _____

WHAT ARE THE TOP 3 CONCERNS THAT YOU HAVE IN YOUR RELATIONSHIP?
(1 being the most problematic):
1. _____
2. _____
3. _____