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**PSYCHOTHERAPY INFORMATION AND CONSENT FORM**

***RISKS AND BENEFITS:*** PSYCHOTHERAPY CAN HAVE BOTH RISKS AND BENEFITS. THE THERAPY PROCESS MAY INCLUDE DISCUSSIONS OF YOUR PERSONAL CHALLENGES AND DIFFICULTIES, WHICH CAN ELICIT UNCOMFORTABLE FEELINGS SUCH AS SADNESS, GUILT, ANGER AND FRUSTRATION. HOWEVER, THERAPY HAS BEEN SHOWN TO HAVE MANY BENEFITS. IT CAN OFTEN LEAD TO BETTER INTERPERSONAL RELATIONSHIPS, IMPROVED WORK/ACADEMIC PERFORMANCE, SOLUTIONS TO SPECIFIC PROBLEMS, AND AN INCREASED CAPACITY TO MANAGE INTENSE FEELINGS. BUT, THERE IS NO ASSURANCE OF THESE BENEFITS. THERAPY REQUIRES YOUR VERY ACTIVE INVOLVEMENT IN ORDER TO WORK TOWARDS GROWTH. I WILL BE COMMITTED TO THIS PROCESS AND WORK HARD FOR YOU, AND I WILL ASK YOU TO DO THE SAME.

***CONFIDENTIALITY:*** IN KEEPING WITH ETHICAL STANDARDS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS AND STATE AND FEDERAL LAW, ALL SERVICES I PROVIDE ARE KEPT CONFIDENTIAL, EXCEPT AS NOTED BELOW. AT TIMES, I MAY CONSULT AS NEEDED WITH SUPERVISORS OR COLLEAGUES ABOUT THE BEST WAY TO PROVIDE THE ASSISTANCE THAT YOU MIGHT NEED. AS REQUIRED BY SOCIAL WORK PRACTICE GUIDELINES AND CURRENT STANDARDS OF CARE, I KEEP RECORDS OF YOUR THERAPY. NEITHER THE FACT THAT YOU SEEK THERAPY, NOR ANY INFORMATION DISCLOSED IN THE THERAPY SESSIONS WILL BE DISCLOSED EXCEPT AS REQUESTED BY YOU AND AS NOTED IN THE EXCEPTIONS BELOW..

I HAVE A LEGAL RESPONSIBILITY TO DISCLOSE PATIENT INFORMATION WITHOUT PRIOR CONSENT WHEN A PATIENT IS LIKELY TO HARM HIMSELF/HERSELF OR OTHERS, UNLESS PROTECTIVE MEASURES ARE TAKEN, WHEN THERE IS REASONABLE SUSPICION OF ABUSE OF CHILDREN, DEPENDENT ADULTS OR THE ELDERLY, WHEN THE CLIENT LACKS THE CAPACITY TO CARE FOR HIM OR HERSELF AND WHEN THERE IS A VALID COURT ORDER FOR THE DISCLOSURE OF CLIENT FILES. FORTUNATELY THESE SITUATIONS ARE INFREQUENT. BY SIGNING THIS FORM YOU ALSO GIVE ME PERMISSION TO COMMUNICATE WITH THE EMERGENCY CONTACT THAT YOU HAVE DESIGNATED IF I BELIEVE THAT YOU ARE AT RISK. PLEASE CONSULT WITH ME IF YOU HAVE ANY QUESTIONS ABOUT CONFIDENTIALITY.

***CANCELLATION POLICY:*** CONSISTENCY IS ESSENTIAL FOR EFFECTIVE THERAPY. AS PART OF OUR TREATMENT COMMITMENT, YOU MAY HAVE 4 CANCELLATIONS WITHOUT CHARGE PER CALENDAR YEAR. IF YOU ARE LATE OR DO NOT ARRIVE FOR A SESSION, YOU ARE STILL FINANCIALLY RESPONSIBLE FOR THE TIME WE HAVE SCHEDULED. IN ORDER TO CANCEL A SESSION WITHOUT CHARGE, I REQUIRE ONE-WEEK'S NOTICE. IF YOU ARE REQUIRED TO MISS ADDITIONAL SESSIONS, YOU WILL BE CHARGED, BUT WE WILL TRY TO RESCHEDULE OUR SESSION AT A MUTUALLY WORKABLE TIME.

***FEES:*** WE WILL AGREE UPON A FEE AT OUR FIRST SESSION. ALL FEES ARE DUE AT THE TIME OF SESSION, UNLESS WE MAKE ALTERNATIVE ARRANGEMENTS. ALL PHONE CONTACT, OTHER THAN SCHEDULING, WILL BE BILLED AT THE HOURLY RATE UNLESS ALTERNATIVE ARRANGEMENTS HAVE BEEN MADE. IN GENERAL, YOUR FEE WILL BE ASSESSED ANNUALLY, THOUGH CONDITIONS MAY WARRANT MORE FREQUENT ASSESSMENT.

**PLEASE SIGN BELOW TO INDICATE THAT YOU UNDERSTAND AND AGREE TO PARTICIPATE IN THERAPY IN ACCORD WITH THE ABOVE POLICIES.**

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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**COUPLES THERAPY INTAKE FORM**

LAST NAME:	FIRST NAME:	MIDDLE NAME:
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TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  MALE  FEMALE

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ - \_\_\_\_\_

CELL/ALTERNATE.: ( ) \_\_\_\_\_ - \_\_\_\_\_

FAX: ( ) \_\_\_\_\_ - \_\_\_\_\_ E-MAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

TELEPHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION**

COMPANY NAME: \_\_\_\_\_ POLICY HOLDER'S NAME: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAYTIME PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ EVENING: ( ) \_\_\_\_\_ - \_\_\_\_\_

CELL/ALT: ( ) \_\_\_\_\_ - \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

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WHERE WERE YOU BORN? \_\_\_\_\_

WHAT IS YOUR ETHNIC IDENTITY? \_\_\_\_\_

RELIGIOUS PREFERENCE: \_\_\_\_\_

DO YOU WORK AT THE PRESENT TIME?

- \_\_\_\_\_ No
- \_\_\_\_\_ YES, FULL OR PART TIME? \_\_\_\_\_
- \_\_\_\_\_ STUDENT, FULL OR PART TIME? \_\_\_\_\_
- \_\_\_\_\_ HOMEMAKER
- \_\_\_\_\_ RETIRED
- \_\_\_\_\_ SUPPORTED BY SAVINGS, FAMILY, ETC...

IF YOU ARE EMPLOYED, WHERE DO YOU WORK? \_\_\_\_\_

WHAT IS THE NATURE OF YOUR WORK?

\_\_\_\_\_

\_\_\_\_\_

HOW LONG HAVE YOU BEEN AT YOUR PRESENT JOB? \_\_\_\_\_

WHAT WERE YOUR PREVIOUS JOBS?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHAT IS THE HIGHEST GRADE OF SCHOOL YOU COMPLETED?

\_\_\_\_\_

\_\_\_\_\_

IF YOU ARE A STUDENT, WHERE DO YOU ATTEND SCHOOL?

\_\_\_\_\_

LIST ANY MAJOR PHYSICAL ILLNESS, HOSPITALIZATIONS, ACCIDENTS THAT YOU HAVE HAD AND AT WHAT AGE THEY OCCURRED:

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD PAST PSYCHIATRIC HOSPITALIZATIONS? \_\_\_\_\_ Yes \_\_\_\_\_ No

IF YES, PLEASE STATE WHERE AND REASON FOR HOSPITALIZATION

\_\_\_\_\_

\_\_\_\_\_

ARE YOU CURRENTLY, OR HAVE YOU PREVIOUSLY PARTICIPATED IN INDIVIDUAL THERAPY? (PLEASE LIST ALL THERAPY RELATIONSHIPS)

\_\_\_\_\_

\_\_\_\_\_

WAS THIS A HELPFUL TREATMENT RELATIONSHIP? \_\_\_\_\_ Yes \_\_\_\_\_ No

PLEASE DESCRIBE:

\_\_\_\_\_

\_\_\_\_\_

ARE YOU CURRENTLY OR HAVE YOU PREVIOUSLY BEEN UNDER THE CARE OF A PSYCHIATRIST?

\_\_\_\_\_ Yes \_\_\_\_\_ No

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CURRENT PSYCHIATRIST'S NAME AND PHONE NUMBER:

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WHAT PRESCRIBED MEDICATIONS DO YOU TAKE, IF ANY?

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WHAT RECREATIONAL SUBSTANCES DO YOU USE / HAVE YOU USED IN PAST (PLEASE INCLUDE ALCOHOL AND CIGARETTES)?

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HOW OFTEN DO YOU USE THESE SUBSTANCES (IF NOT CURRENTLY USING, HOW OFTEN IN PAST)?

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DO YOU CONSIDER ANY OF YOUR SUBSTANCE USE TO BE A PROBLEM?  YES  NO  
IF YES, PLEASE DESCRIBE:

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HAVE YOU RECEIVED HELP FOR DRUG OR ALCOHOL DEPENDENCY?  YES  NO  
PLEASE DESCRIBE:

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DO YOU HAVE ANY PROBLEMS OR WORRIES ABOUT SEXUAL FUNCTIONING?  YES  NO  
(CHECK ALL THAT APPLY)

- CONCERNS WITH SEXUAL AROUSAL OR SEXUAL INTEREST
- COMPULSIVE SEXUAL BEHAVIOR
- CONCERNS ABOUT SEXUAL INTERESTS AND SEXUAL ORIENTATION
- ERECTILE DYSFUNCTION
- EJACULATING TOO QUICKLY
- TROUBLE REACHING ORGASM
- PAINFUL INTERCOURSE
- OTHER

ARE YOU HAVING ANY PROBLEMS WITH YOUR SLEEP HABITS?  YES  NO  
(IF YES, CIRCLE WHERE APPLICABLE)

SLEEPING TOO LITTLE    SLEEPING TOO MUCH    POOR SLEEP    DISTURBING DREAMS    OTHER

USE THIS SPACE TO DESCRIBE SLEEP ISSUES:

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HOW MANY TIMES A WEEK DO YOU EXERCISE? \_\_\_\_\_  
FOR ABOUT HOW LONG EACH TIME? \_\_\_\_\_  
WHAT TYPE OF EXERCISE DO YOU DO? \_\_\_\_\_

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WHAT ACTIVITIES DO YOU ENJOY DOING IN YOUR FREE TIME?

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ARE YOU HAVING ANY DIFFICULTY WITH APPETITE OR EATING HABITS? \_\_\_\_ YES \_\_\_\_ NO  
 (IF YES, CIRCLE WHERE APPLICABLE)

EATING LESS    EATING MORE    BINGING    RESTRICTING    SIGNIFICANT WEIGHT CHANGE

**FAMILY BACKGROUND QUESTIONS**

PLEASE LIST THE MEMBERS OF YOUR CURRENT FAMILY, INCLUDING AGES AND OCCUPATIONS.  
 PLEASE BE SURE TO STATE IF FAMILY MEMBERS ARE BIOLOGICAL, ADOPTIVE, OR OTHER

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PLEASE CHECK ANY PAST OR IMPENDING ISSUES THAT APPLY TO YOU, YOUR PARENTS AND/OR SIBLINGS?

	SELF	MOTHER	FATHER	SIBLING(S) (SPECIFY)
ALCOHOL ABUSE				
DRUG ABUSE				
EMOTIONAL PROBLEMS				
PSYCHIATRIC HOSPITALIZATIONS				
ANXIETY				
DEPRESSION				
OTHER MENTAL ILLNESS				
ULCERS OR COLITIS				
ASTHMA				
SERIOUS PHYSICAL ILLNESS				
WEIGHT/EATING PROBLEMS				
ANOREXIA				
BULIMIA				
INSOMNIA				
ATTEMPTED/ COMPLETED SUICIDE				
EPILEPSY				
PHYSICAL ABUSE				
SEXUAL ABUSE				
DEBILITATING INJURIES/DISABILITIES				
NUMEROUS CHILDHOOD ILLNESSES				
FREQUENT RELOCATIONS				
LEARNING PROBLEMS				
DEATHS				
DIVORCE				
FINANCIAL CRISIS/UNEMPLOYMENT				
LEGAL PROBLEMS				
OTHER				

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ARE YOUR PARENTS MARRIED OR DIVORCED? \_\_\_\_\_

IF DIVORCED, ARE EITHER OF THEM RE-MARRIED/RE-PARTNERED?

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

WHAT DOES YOUR FATHER DO FOR WORK?

\_\_\_\_\_

WHAT DOES YOUR MOTHER DO FOR WORK?

\_\_\_\_\_

HOW MUCH IS YOUR IMMEDIATE FAMILY A SOURCE OF EMOTIONAL SUPPORT FOR YOU? (CIRCLE ONE):  
 NONE                  LITTLE                  SOMEWHAT                  SUBSTANTIAL                  VERY STRONG

BESIDES FAMILY MEMBERS, WHO DO YOU REALLY COUNT ON RIGHT NOW FOR FRIENDSHIP OR EMOTIONAL SUPPORT? (PLEASE NAME AND NOTE RELATIONSHIP TO YOU)

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

**RELATIONSHIP QUESTIONS**

SPOUSE/PARTNER'S NAME: \_\_\_\_\_

- RELATIONSHIP STATUS  
 (CHECK ALL THAT APPLY)  
 MARRIED/COMMITTED  
 SEPARATED  
 DIVORCED  
 DATING  
 LIVING TOGETHER  
 LIVING APART

LENGTH OF TIME IN CURRENT RELATIONSHIP: \_\_\_\_\_

IS MONOGAMY AN EXPECTATION IN YOUR RELATIONSHIP? \_\_\_\_\_

CHILDREN (INCLUDING, BIOLOGICAL, ADOPTED, FOSTER, STEP):

NAME	SEX	AGE	TYPE	CUSTODY

PLEASE CHECK ANY OF THE REASONS LISTED BELOW THAT RESULTED IN YOUR REQUEST FOR THERAPY (IF APPROPRIATE, SPECIFY SELF OR PARTNER):

- DEPRESSION OR ANXIETY \_\_\_\_\_  
 ALCOHOL/DRUG ABUSE \_\_\_\_\_  
 MARITAL PROBLEMS \_\_\_\_\_  
 COMMUNICATION DIFFICULTIES \_\_\_\_\_  
 EXTRAMARITAL AFFAIR/RELATIONSHIP \_\_\_\_\_  
 IMPROVE SEXUAL RELATIONS \_\_\_\_\_  
 CHILD/PARENT CONFLICT \_\_\_\_\_  
 DIVORCE COUNSELING \_\_\_\_\_  
 SEXUAL ORIENTATION QUESTIONS \_\_\_\_\_  
 SUICIDAL THOUGHTS \_\_\_\_\_  
 HOMICIDAL THOUGHTS \_\_\_\_\_  
 LEARNING DIFFICULTIES \_\_\_\_\_

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- DIFFICULTY WITH LOSS OR DEATH \_\_\_\_\_
- RELATIONSHIP ENHANCEMENT \_\_\_\_\_
- ABUSE (PHYSICAL/MENTAL) \_\_\_\_\_
- MEDICAL/PHYSICAL PROBLEM \_\_\_\_\_
- PRE-MARITAL COUNSELING \_\_\_\_\_
- OTHER \_\_\_\_\_

WHAT IS THE PRIMARY ISSUE THAT YOU ARE DEALING WITH IN YOUR RELATIONSHIP?  
\_\_\_\_\_  
\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS ISSUE?  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD SIMILAR ISSUES IN PAST RELATIONSHIPS?  
\_\_\_\_\_  
\_\_\_\_\_

WHY ARE YOU SEEKING HELP NOW? \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU RECEIVED COUPLES THERAPY OR COUNSELING IN THE PAST?  No  YES  
IF YES, WHEN AND WITH WHOM?  
\_\_\_\_\_  
\_\_\_\_\_

OUTCOME:  
\_\_\_\_\_  
\_\_\_\_\_

WHAT ARE YOUR GREATEST STRENGTHS AS A COUPLE?  
\_\_\_\_\_  
\_\_\_\_\_

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF THERAPY?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

