

ERIKA MALM COOLEY, LCSW
LICENSE No. 077332
156 FIFTH AVENUE, SUITE 718, NEW YORK, NY 10010
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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 2 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.

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:

WHAT PRESCRIBED MEDICATIONS DO YOU TAKE, IF ANY?

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

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

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

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

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:

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?

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

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 _____

