

ERIKA MALM COOLEY, LCSW
LICENSE No. 24607
10850 WILSHIRE BLVD, SUITE 740, LOS ANGELES, CA 90024
T: 310.882-6419 F: 310-882-6419 ERIKA@MALMCOOLEY.COM WWW.MALMCOOLEY.COM

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.

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

PRINT NAME

SIGNATURE

DATE

PATIENT INFORMATION

NEW PATIENT FORM 8-09

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LAST NAME:

FIRST NAME:

MIDDLE NAME:

PARENT/GUARDIAN OF PATIENT? NAME/RELATIONSHIP TO PATIENT: _____

TODAY'S DATE: ____/____/____ MALE FEMALE S.S.# _____

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: _____

WHERE WERE YOU BORN? _____

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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

WHAT PRESCRIBED MEDICATIONS DO YOU TAKE REGULARLY, IF ANY?

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PLEASE LIST PREVIOUS MARRIAGES AND/OR SERIOUS RELATIONSHIPS.

PLEASE ANSWER THE FOLLOWING IF YOU ARE WITH YOUR PARTNER NOW:

WHAT IS YOUR PARTNER'S NAME? _____

WHAT IS YOUR PARTNER'S OCCUPATION? _____

PLEASE LIST THE NAMES AND AGES OF YOUR CHILDREN, IF ANY, INCLUDING STEP-CHILDREN.
 PLEASE NOTE IF YOUR CHILDREN ARE BIOLOGICAL OR ADOPTED. IF ADOPTED, PLEASE NOTE AGE
 ADOPTED. IF ANY OF THEM ARE DECEASED, PLEASE LIST DATE THEY DIED:

FAMILY BACKGROUND QUESTIONNAIRE

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				

