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NEW PATIENT INTAKE QUESTIONNAIRE

1. What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

2. What are your goals for counseling?

3. Have you seen a mental health professional before?

Yes

No

4. Specify all medications and supplements you are presently taking and for what reason:

5. If taking prescription medication, who is your prescribing MD? Please include the type of MD, name and phone number.

6. Who is your primary care physician? Please include the type of MD, name and phone number.

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7. Do you drink alcohol?

Yes

No

8. Do you use recreational drugs?

Yes

No

9. Do you have suicidal thoughts?

Yes

No

10. Have you ever attempted suicide?

Yes

No

11. Do you have thoughts or urges to harm others?

Yes

No

12. Have you ever been hospitalized for a psychiatric issue?

Yes

No

13. Is there a history of mental illness in your family?

Yes

No

14. If you are in a relationship, please describe the nature of the relationship and months or years together.

15. Describe your current living situation. Do you live alone, with others. With family, etc.

16. What is your level of education? Highest grade/degree and type of degree.

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17. What is your current occupation? What do you do? How long have you been doing it?

18. Please Circle any of the following you have experienced in the past six months:

Increased appetite	Low self-esteem
Decreased appetite	Depressed mood
Trouble concentrating	Tearful or crying spells
Difficulty sleeping	Anxiety
Excessive sleep	Fear
Low motivation	Hopelessness
Isolation from others	Panic
Fatigue/low energy	Other:

19. Please check any of the following that apply:

Seizures	High blood pressure	Gastritis or esophagitis
Hormone-related problems	Head injury	Angina or chest pain
Irritable bowel	Chronic pain	Loss of consciousness

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Heart attack	Bone or joint problems	Seizures
Kidney-related issues	Chronic fatigue	Dizziness
Faintness	Heart valve problems	Urinary tract problems
Fibromyalgia	Numbness & tingling	Shortness of breath
Diabetes	Hepatitis	Asthma
Arthritis	Thyroid issues	HIV/AIDS
Cancer	Other:	

What else would you like me to know?

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Release of Information Consent

* indicates a required field

* Client's name:

* I authorize [ ] to:

Send

Receive

The following information:

Medical history and evaluation(s)

Mental health evaluations

Developmental and/or social history

Educational records

Progress notes, and treatment or closing summary

Other

To / From:

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Phone:

* Your relationship to client:

Self

Parent/legal guardian

Personal representative

Other

* The above information will be used for the following purposes:

Planning appropriate treatment or program

Continuing appropriate treatment or program

Determining eligibility for benefits or program

Case review

Updating files

Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse

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Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* Signature: _____

* Date: _____

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Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

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If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

If a client threatens grave bodily harm or death to another person.

If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

Suspected neglect of the parties named in items #3 and # 4.

If a court of law issues a legitimate subpoena for information stated on the subpoena.

If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel

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it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

* Signature: _____

* Date: _____

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS Please remember to cancel or reschedule 24 hours in advance. You will be responsible for a $50 fee if cancellation is less than 24 hours.

The reason for this fee is not intended to be punitive but to ensure clients will have a time slot when needing an appointment. No shows and late cancellations leave a space where someone who needs help could have been seen.

The standard meeting time for psychotherapy is 50 minutes.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please text /call (678) 897-3445. I may not be immediately available; however, I will attempt to return your call/ text within 24 business hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If an emergent situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or

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contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via client portal I I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California.

Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

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(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel

costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures,

physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he

or she would consider important information that you may not recognize as significant to present verbally to the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

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TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

* Signature: _____

* Date: _____