

Client Questionnaire

Name _____ Age _____ Date of birth _____

Marital status _____ Educational level _____ Occupation _____

Referred by _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe.

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?

Medical History*

Do you have any medical conditions that may affect your mental health treatment?

What is the date of your last physical? Please describe your overall health today.

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

Do you smoke? How much? For how long?

Do you drink alcohol? _____ On average, how much alcohol do you consume in a week? _____

Have you ever been in a 12-step program? _____

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Family of Origin History

Mother's name, age, living/deceased, client's age at the time of mother's death:

Father's name, age, living/deceased, client's age at the time of father's death:

Names and ages of siblings:

Names and ages of children:

Are there any significant events from your past that you believe contribute to your current feeling of well being?

Psychological History*

Have you ever received mental health treatment before? When and for how long?

Have you ever been hospitalized for mental or emotional problems? When and for how long?

Are you currently taking any prescription medications? How long have you been on the medications?

Have you ever taken any medications for a mental or emotional condition? When and for how long?

Have you ever attempted suicide? When? Describe the circumstances that led to that attempt.

Are you currently having any suicidal thoughts? Please describe _____

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Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? Please describe.

Have you ever been a victim of a violent crime? Please describe

Please feel free to include any other information that you believe is relevant to your
mental health treatment, not previously requested.

*Authorization for release of confidential information will be needed from the client in order to contact
any individual other than the client.

Disclosure Statement & Agreement for Services

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Note: The therapist should indicate his/her licensure status before the client completes this form.

Your therapist is a:

- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Psychologist
- Marriage and Family Therapist Registered Intern*
- Marriage and Family Therapist Trainee*
- Associate Clinical Social Worker*
- Psychological Assistant*
- Registered Psychologist*

* If your therapist is a Marriage and Family Therapist Registered Intern, Marriage and Family Therapist Trainee, Associate Clinical Social Worker, Psychological Assistant or Registered Psychologist, his/her practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and licensure are listed below:

Gary Pearle, M.A., PhD. License # MFC 30246
Name of Clinical Supervisor/License Type/License Number

(Note: If the therapy practice uses a fictitious business name, the name and license designation of the business owners must be disclosed. Similarly, if the business is a professional corporation, the client must be informed of that fact.)

Information About This Practice (as applicable)

The name of this practice is: *Gary D. Pearle , PhD. Individual and Relationship Psychotherapy*

The individual therapist(s) who operate this practice is/are: *Gary D. Pearle, PhD*

Name of Therapist/Supervisor License Type License Number: *Gary D. Pearle, PhD, MFC# 30246*

Name of Therapist/Intern License Type License Number: *Brian Carlson, M.A., MFT Intern #53366*

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Fees and Insurance

- Individual therapy session is \$80.00 per. Individual Sessions are 50 minutes in length.
- Conjoint (marital /family) therapy session is \$125.00 per. Conjoint sessions are 75 minutes in length.
- Group therapy session is \$30.00 per person per group (6 person minimum per group). Group therapy sessions are 90 minutes in length.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time. Please discuss any questions or concerns that you may have about this with your therapist.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

No Secrets Policy

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her “no secrets” policy and how it may apply to you.

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INFORMED CONSENT

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. Prorated fees will apply to telephone consultations.

Nonurgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapists Limited Availability

The therapist's limited availability, i.e. travel, illness, or personal commitment, will be communicated directly to the client or communicated through the therapist's outgoing voicemail message. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Due to the nature of the therapist's absence return call times may vary. The therapist will provide an alternative therapist's contact information for nonurgent situations.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

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Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

- My therapist may call me at my home.
My home phone number is: _____
- My therapist may call me on my cell phone.
My cell phone number is: _____
- My therapist may call me at work.
My work phone number is: _____
- My therapist may send mail to me at my home address.
My Home Address is: _____
- My therapist may send mail to me at my work address.
My Work Address is: _____
- My therapist may communicate with me by email.
My email address is: _____
- My therapist may send a fax to me.
My fax number is: _____
- In case of an emergency, my therapist may contact:

Emergency Contact Information

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

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SIGNATURE PAGE

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign!

Client Name (Print)

Signature

Date