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COUNSELING & CONSULTATION

## Client Identification Form

Client Legal Name: _____

Client Preferred Name:_____

Date of Birth:_____

Home Address:_____

Telephone Number:_____
-Ok to leave voicemail messages? YES / NO
-Ok to receive text messages? YES / NO

Email Address:_____

Emergency Contact:
_____
_____

# Office Policies & General Information Agreement for Counseling

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# Services or Informed Consent for Counseling

## Counselor-Patient Service Agreement

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care options. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are lengthy and complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**Qualifications:** I am a Licensed Social Worker practicing as an employer under the agency Rewired Path. I have a Master's Degree in Clinical Social Worker. I am supervised by a Licensed Clinical Social Worker, Lisa Cordasco, who is a co-founder of Rewired Path and certified as a clinical supervisor. I adhere to the National Association of Social Workers' Code of Ethics.

## PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general terms or statements, it varies depending on the personalities of the therapist and patient, as well as the particular problems you experience and are willing to address. There are many different methods I may use to aid you in coping and healing with the problems that you set forth to address throughout your treatment. Psychotherapy is not like a medical doctor visit, as it involves a large commitment of time, money, and energy, calling for a very active effort on your part. In order for therapy to be most beneficial you will have to work on issues we address both during and after our scheduled sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, shame, anger, frustration, loneliness, inferiority, and helplessness. Subsequently, psychotherapy has also been shown to have enormous benefits, often leading to greater awareness and insight, healthier decision making, improved interpersonal relationships, efficient problem solving and significant reductions in emotional disturbance and feelings of distress. However, there are no guarantees of what you will experience throughout the course of your participation in services.

**CONFIDENTIALITY LIMITS**

The law protects the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written consent/authorization form that meets certain legal requirements imposed by HIPPA. There are other situations that do not require your written, advance consent. Your signature on this form provides consent for those activities, as follows:

**CONSULTATION & SUPERVISION:**

-You should be aware that as a beginning license (LSW) social worker I am required to be supervised by an LCSW with the required supervisory certificate while I pursue completion of my hours to obtain my LCSW. As part of my required supervision I may discuss aspects of your case with my supervisor for the purpose of guidance legally and ethically on care, as well as for improving my continued skill and practice. My supervisor is Lisa Cordasco, who is an LCSW and an LCADC who is certified as a supervisor in the state of New Jersey and is a co-owner of this practice. Lisa can be reached at 732-778-1019 if needed.

-I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important for our work together. I will note all consultations in your clinical record.

-You should be aware that I practice with other addiction and mental health professionals. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling and billing. All of the addition and mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting

your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
***There are some situations where I am permitted or required to disclose information without your consent or authorization. They are as follows***:

**LITIGATION:**
-If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose case information.
-If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
-If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

**EMERGENCY:**
I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm. Therefore, I may have to reveal some information about a patient's treatment if:
-I have reasonable cause to believe that a child has been subject to abuse or neglect, the law requires that I must report it to the Division of Child Protection and Permanency (DCP&P) and proper authorities. Once such report is filed, I may be required to provide additional information.
- I have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and I believe that the disclosure is necessary to prevent serious harm to the patient or other potential victims, I may report the information to the county adult protective services provider. Once such report is filed, I may be required to provide additional information.
-If a patient communicates a threat, or if I believe that patient presents a threat of imminent serious physical harm against a readily identifiable individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
-If I believe the patient presents a threat of imminent danger to him/herself, I may be required to take protective actions. These actions may include contacting the

police or others who could assist in protecting the patient or seeking hospitalization for the patient.
If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.
While this written summary of expectations to confidentiality should prove helpful in informing you about the potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed or required.

**HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:**
Disclosure of confidential information may be required by your health insurance carrier. Only the minimum necessary information will be communicated to the carrier. However, I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information. Be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access.

**MINORS AND PARENTS/LEGAL GUARDIANS**
Patients under 18 years of age, who are not emancipated, and their parent(s)/legal guardian(s) should be aware that the law may allow parent(s)/legal guardian(s) to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise.
Because privacy in psychotherapy is crucial to successful treatment outcomes, particularly with teenagers, it is sometimes my policy to request an agreement from parent(s)/legal guardian(s) consenting to give up their access to their child's treatment records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, as well as his/her attendance and scheduled sessions. I will also provide parent(s)/legal guardian(s) with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization. In the event that I feel that the child is in danger to themselves or someone else parent(s)/legal guardian(s) will be notified of my concern. Before giving parent(s)/legal guardian(s) any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

**E–MAILS, MOBILE PHONES, COMPUTERS, AND FAXES:**
It is very important to be aware that computers and unencrypted email, texts, and e-faxes communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Servers or communication companies may have unlimited and direct access to all electronic communication that goes through them. Please notify me if you decide to avoid or limit, in any way, the use of particular communication technologies such as email, texts, cell phones calls, phone messages, or e-faxes. Otherwise, it is assumed that you have made an informed decision.

**RECORDS AND YOUR RIGHT TO REVIEW THEM:**
Both the law and the standards of my licensing board require that treatment records be kept for at least seven years. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to receive a summary of your records, except when I believe that releasing such information might be harmful in any way or in limited legal or emergency circumstances or. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify unless I assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family counseling, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

**SOCIAL NETWORKING AND INTERNET SEARCHES:** As an individual clinician, I do not accept friend requests from current or former clients on social networking sites, such as Facebook, nor do I respond to any inbox messages for current or former clients. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise the therapeutic relationship and threaten privacy and confidentiality.

**GROUP COUNSELING:** In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the

reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

**CASE MANAGEMENT**

Please note that any letters, documentation or outreach requested or required outside of direct therapeutic services and receipt of services will require one week of notification and are subject to an additional fee for case management.

**CONTACTING ME**

Due to my work schedule, I am often not immediately available by phone. When I am unavailable, my telephone is answered by confidential voicemail that I monitor frequently. Please note that if you do not leave a voicemail message, you may not receive a call back. I will make every effort to return your voicemail message on the same day it is received, with the exceptions of weekends, holidays and scheduled vacations. If you are experiencing an emergency with a failed attempt at reaching me, please be sure to contact 911 or proceed immediately to your local ER/crisis unit. Below you will find a list of helpful hotlines that may also assist you in emergency in the event that I am not available.

If you need to talk to someone right away, call the Psychiatric Intervention Program (PIP) at Atlantic City Medical Center-City Division, 1925 Pacific Avenue to reach the county's 24 hour emergency hotline at **609-344-1118.** PIP is:

- Located in the Emergency Center of AtlantiCare Regional Medical Center City Campus, Atlantic City
- Available 24 hours a day, 7 days a week
- Can provide telephone referral, support and guidance
- Provides evaluation and appropriate referral for clients to outpatient mental health services or inpatient treatment

You can also call PIP's **Crisis Mobile Outreach, also located at** AtlantiCare Regional Medical Center at **609-226-1791. Mobile Outreach is:**

- Available 8 a.m. to 8 p.m. Monday through Friday
- Provides on-site evaluation and support for individuals experiencing a psychiatric crisis

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Other Helpful Hotlines Include:
**-National Suicide Prevention Lifeline: 1-800-273-8255**
**- NJ Suicide Prevention Hopeline: 1-855-654-6735**
**- Addictions Hotline: 1-800-238-2333**
**- NJ Domestic Violence Hotline: 1-800-572-7233**
**-NJ Human Trafficking Hotline: 1-877-986-7534**

Please note that the link below is for the **Crisis Text Line**, which is easily accessible by anyone in need of some extra support during a crisis through texting. They also provide linkage to coping skills. This is a 24/7 service, and more information can be found on their website (see link below). It certainly does not take the place of mental health treatment but can be an extra support for individuals who may need contact outside of their therapy appointments.
To access, you only need to text "Home" to 741-741, and in about 15 minutes or less a worker will reach out to you via text. You will also get a link to online resources for coping skills. I believe it is also anonymous, but I am not certain on that point.
https://www.crisistextline.org/

Please also note that **text messaging is *NOT* used a preferred method of communication**. Text messaging is only used as a means to coordinate and schedule appointments as well as to confirm preexisting scheduled appointments. All other communications must be handled via telephone, email, or in session.

**SESSIONS**

A typical therapy session is scheduled once per week, for 60 minutes at a time and day we agree upon. **Once an appointment is selected, you will be expected to pay the full-session fee unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled appointments.**
Please note that it is *strongly* recommended that we **take a minimum of 2 termination sessions together prior to the completion of your treatment**. This recommendation is in place in order to protect the integrity of the work we will be doing together and is also a means of avoiding the impulsive decision to terminate treatment prematurely.
Endings in therapy are extremely important to discuss and acknowledge. If you choose to end therapy and wish to enter into therapy with a different provider, I will provide you with appropriate referrals. On some occasions, it is the therapist who may choose to


end a therapeutic relationship. Reasons for this may include: a client's persistent use of therapy-destroying behaviors, a client's need for services I am unable to provide (such as treatment for an area outside of my expertise and training or at a higher level of care), and/or reasons related to my own circumstances or limitations. If you commit violence towards me, verbally or physically threaten or harass me, or my family, I reserve the right to terminate your treatment unilaterally and immediately. Failure or refusal to pay for services after a reasonable period of time is another condition for termination of services.

*Your signature below indicates that you have read this agreement and agree to its terms.*

_____Client Printed Name

_____
Client Signature / Date

_____
Counselor Signature/Date


Cancellation Policy

I understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, I respectfully ask that you provide 24 hours notice when you are unable to keep a previously scheduled appointment.

I strive to keep appointments available to you and to all of my clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen.

**If your appointment is not cancelled at least 24 hours in advance, or you do not show to your scheduled appointment, you will be charged a $60.00 cancellation fee. Please note that this fee will not be covered by your health insurance company.**

Thank-you for your understanding and cooperation with this policy.

By signing below I acknowledge that I have read and understand this cancellation policy:

Client/Guardian Name:
_____

Signature: _____
Date:_____

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# Consent for Telehealth Sessions

1. I understand that my health care provider has offered me the option of engaging in a telehealth psychotherapy session.

2. My health care provider explained to me how the video conferencing technology that will be used to access such a session will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

6. I agree to sign the Emergency Contact for Telehealth Release of Information before my scheduled telehealth session and share my address with my health care provider at the beginning of each session.

7. I understand that the telehealth platform is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

8. Though my provider and I may be in direct, virtual contact through the telehealth platform, the telehealth platform does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

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9. The telehealth platform facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

10. I do not assume that my provider has access to any or all of the technical information involved in operating the telehealth platform – or that such information is current, accurate or up-to-date.

11. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

1. That I have read or had this form read and/or had this form explained to me.

2. That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature _____ Date_____

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# Telehealth Emergency Contact -Release of Information

If you have a mental health emergency, and you have exhausted all skills options, I encourage you not to wait for communication back from me, but to do one or more of the following:

- Call Lifeline at (800) 273-8255 (National Crisis Line)

- Call 911

- Go to the emergency room of your choice

Emergency procedures specific to Telehealth services:

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.
Please list your ECP below:

**Name:**

Phone:

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You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

**Hospital**

Phone:

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list this police department and contact number here:

**Police Department:**

Phone:

**I understand the content of this agreement in relation to Telehealth services:**

**Signature _____ Date_____**

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# Record to Obtain and Release of Information

I, _____, hereby give

permission to: (Clinician Name)_____ **& Rewired Path** to

obtain/release from my file (s) the following information: (Please Check)

**Evaluation Results____ Attendance____ Progress in Treatment____**

**Treatment Plans____ Progress Notes/Observations____ Discharge Summary____**

**Other:**_____

This information is to obtained/released from/to:

_____

The purpose or need for such disclosure is:

_____

Revocation/Expiration: This release of information is subject to revocation by the under- signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a date stated here (_____), this release of information will automatically expire after a period of 180 days from the date signed. I have the right to receive a copy of this release of information upon my request.

X_____ Date: _____

Signature of Patient or Person authorized by law to give consent

X_____ Date: _____

Signature of Witness

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# Record to Obtain and Release of Information

I, _____, hereby give

permission to: (Clinician Name)_____ **& Rewired Path** to

obtain/release from my file (s) the following information: (Please Check)

**Evaluation Results____ Attendance____ Progress in Treatment____**

**Treatment Plans____ Progress Notes/Observations____ Discharge Summary____**

**Other:**_____

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X_____ Date: _____

Signature of Patient or Person authorized by law to give consent

X_____ Date: _____

Signature of Witness

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# Intake Form

***Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.***

NAME:_____
DATE: _____
PARENT/LEGAL GUARDIAN (if under 18):
_____

ADDRESS:
_____
HOME PHONE: _____

CELL/WORK/OTHER PHONE: _____
EMAIL:
_____
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ AGE: _____
GENDER: _____ MARITAL STATUS: _____
SPOUSE/PARTNER'S NAME:_____
CHILDREN (Names & Ages):
_____
_____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE:
_____

PERSON & PHONE NO. TO CONTACT IN EMERGENCY:
_____

REFERRAL SOURCE:
_____

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CURRENT OCCUPATION (former, if retired):
_____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

**FAMILY MENTAL HEALTH HISTORY**
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| Condition | Please circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Sexual Abuse | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |

| | | |
|---|---|---|
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |
| Other diagnosed mental health condition? | yes/no : which was--- | |

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____
_____
_____

_____
_____

IF PARENTS DIVORCED: Your age at the time: _____.

Describe how it affected you at the time

_____
_____

_____
_____

WHO IS YOUR CURRENT IDENTIFIED SUPPORT SYSTEM?

_____
_____

**PERSONAL HISTORY**

HAVE YOU PREVIOUSLY RECEIVED ANY BEHAVIORAL HEALTH TREATMENT? □ No □ Yes


If yes, which of the following:

□ Psychotherapy □ Medication □ Outpatient Hospitalizations □ Inpatient Hospitalization

PLEASE PROVIDE:

Name of provider or facility, Location and Dates Attended

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

PRIOR REASON FOR TREATMENT:

_____
_____

Comments/Feedback on your overall experience of prior treatment:

_____
_____
_____

HAVE YOU EVER BEEN PRESCRIBED ANY PSYCHIATRIC MEDICATION?
□ Yes □ No
If yes, please list and provide dates:

_____
_____
_____

CURRENT MEDICATIONS:

_____
_____

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ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST?
□ Yes □ No
If so, Please list name and phone number:
_____

If not, are you interested in discussing a referral to a psychiatrist as part of your care? _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (Identify any Treatments or 12-step involvement as well as substances used):
_____
_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)
_____
_____

PRIOR DISORDERED EATING HISTORY?
_____

MEDICAL DOCTOR (S) (name/phone):
_____
_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):
_____
_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION FOR A MEDICAL ISSUE? □ Yes □ No
If yes, please list medication name and reason:
_____
_____
_____

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HOW WOULD YOU RATE YOUR OVERALL PHYSICAL HEALTH? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

HOW WOULD YOU RATE YOUR CURRENT SLEEPING HABITS? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

HOW MANY TIMES PER WEEK DO YOU GENERALLY EXCERCISE?

_____

WHAT TYPES OF EXERCISE DO YOU PARTICIPATE IN?

_____

HOW WOULD YOU RATE YOUR CURRENT NUTRITION? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING SADNESS, GRIEF OR DEPRESSION?

□ No □ Yes

If yes, for approximately how long?_____

ARE YOU CURRENTLY EXPERIENCING ANXIETY, PANIC ATTACKS OR PHOBIAS?

□ No □ Yes
If yes, when did you begin experiencing this?
_____

ARE YOU CURRENTLY EXPERIENCING INTRUSIVE THOUGHTS OR MEMORIES ABOUT THE PAST?
□ No □ Yes
If yes, when did you begin experiencing this?
_____

ARE YOU CURRENTLY EXPERIENCING ANY CHRONIC PAIN?
□ No □ Yes
If yes, please describe:
_____

DO YOU DRINK ALCOHOL MORE THAN ONCE A WEEK? □ No □ Yes
If Yes, on average how many times per week? _____
If Yes, are you concerned about you drinking habits? _____

HOW OFTEN DO YOU ENGAGE IN RECREATIONAL DRUG USE?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
If so, what drugs do you use? _____
_____

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? □ No □ Yes
If yes, for how long?
_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):
Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____
Browsing: _____


Work/School: _____ Other: _____

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

_____
_____
_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____
_____
_____

WHAT SIGNIFICANT LIFE CHANGES OR STRESSFUL EVENTS HAVE YOU EXPERIENCED LATELY?

_____
_____
_____

WHAT IS YOUR CURRENT EMPLOYMENT SITUATION? (Do you enjoy your work? Is there anything stressful about your current work?)_____
_____
_____
_____

DO YOU CONSIDER YOURSELF TO BE SPIRITUAL OR RELIGIOUS?
□ No □ Yes
If yes, describe your faith or belief:

_____
_____
_____

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WHAT DO YOU CONSIDER TO BE SOME OF YOUR STRENGTHS?

_____
_____
_____

WHAT DO YOU CONSIDER TO BE SOME OF YOUR WEAKNESSES?

_____
_____
_____

WHAT GIVES YOU THE MOST JOY AND PLEASURE IN YOUR LIFE?

_____
_____
_____

WHAT ARE YOUR MAIN WORRIES OR FEARS?

_____
_____
_____

WHAT ARE YOUR MOST IMPORTANT HOPES AND DREAMS?

_____
_____
_____

WHAT WOULD YOU LIKE TO ACCOMPLISH OUT OF YOUR TIME IN THERAPY?

_____
_____
_____

*Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.*

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# Client Credit Card Information

*(Please note, this information is kept on file in the event of no call/no show as outlined in the prior policies. We will not bill your card otherwise without your consent or permission to do so.)*

Client Name:_____

Name on Credit Card:_____


Type of Card:_____

Credit Card Number:_____

Security Code:_____

Expiration Date:_____

Billing Zip Code:_____