CLIENT INFORMATION

Information contained in this form will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. **Please fill out completely**.

Name(s) _____ **Date** _____

Age _____ Gender _____ Cell Phone (_____)_____

Referred By:

- ❑ Friend/Relative
- ❑ Internet/Website
- ❑ Client
- ❑ Staff
- ❑ Church: _____
- ❑ School: _____
- ❑ Other: _____

Office Location

(Circle one): Santa Ana Los Alamitos Brea Costa Mesa Torrance

Name of Therapist _____

PERSONAL DATA (1)

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date _____ **Referred By** _____

Client: Name _____ Gender _____

Address_____ City_____ Zip Code_____

Primary Phone # (_____)_____ Email: _____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

Person to notify in case of emergency_____Relationship_____

Phone number_____

NOTE: It is important for the client and therapist to determine together what part of spiritual/religious issues will or will not take place in therapy.

Would you like spirituality/religious issues to be a part of your therapy? Y ❑ N ❑ Don't Know ❑

Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5

Mildly Upsetting *Extremely Serious*

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $ _____ per session which is payable at the time of the session.

Client Signature _____

Therapist Initials _____ **(over)**

FAMILY INFORMATION

Marital status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Parents: Father: Age _____ Occupation_____ Mother: Age _____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

Sibling(s): Age(s) _____ **Spouse/Partner:** Age _____ Occupation_____

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you experienced or witnessed Domestic Violence? Y ❑ N ❑ **Have you experienced a traumatic head injury**? Y ❑ N ❑

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y ❑ N ❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Height_____ Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

Are you currently covered by Medicare? Y ❑ N ❑

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hear/See things that others don't see/hear	❑	❑	❑	❑

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

CONSENT TO TREATMENT (1)

Welcome to the Center for Individual & Family Therapy, a Christian counseling center. The following is an agreement to enter in to an INITIAL INTAKE/TREATMENT PROCESS.

INITIAL INTAKE SESSION: The first session is an initial intake. It is sometimes necessary to refer you to another CIFT clinician who can better meet your needs. If, for some reason we are not able to help you at CIFT, we will provide referrals to an outside therapist.

APPOINTMENTS: It is your responsibility to notify your therapist at least 48 hours in advance if you are unable to attend your appointment. **Cancellations of appointments less than 48 hours in advance and "no shows" are subject to the full fee charge for the appointment time.**

ELECTRONIC COMMUNICATION AND EMERGENCY PROCEDURES: If you choose to contact your therapist electronically, your therapist will not respond in kind without prior written authorization from you. If your therapist is in agreement, you may authorize your therapist to communicate with you through email and/or text messaging as a supplement to communication via telephone. Emails and text messages should be limited in nature and will not take the place of in session communication. Please note, email and text messages, like most forms of electronic communication, are not completely secure or confidential. Therefore, CIFT cannot guarantee confidentiality of any therapeutic content, including but not limited to information regarding danger to one's self or others, if communicated through email or text message. Please note, sending an email or text message does not mean your therapist has had the opportunity to read your message. Your therapist will only review and respond to emails or text messages within normal business hours, which are Monday through Friday from 9am to 7pm. Emails and texts sent outside of normal business hours will generally be responded to either the next business day or as soon as the therapist deems necessary for all non-emergency communication. In case of an emergency, please ***first*** call 911 or proceed to the nearest hospital emergency room; then, if possible, you may contact your therapist about emergency issues.

TREATMENT: CIFT therapists approach treatment by employing varying schools of thought including, but not limited to, EMDR (Eye Movement Desensitization Reprocessing), Cognitive-Behavioral (CBT), Psychodynamic, and Family System therapies. EMDR therapy was originally developed to treat trauma symptoms. It utilizes bilateral stimulation for treatment of a variety of symptoms and conditions. Cognitive-Behavioral therapies look at the interaction of thoughts and behaviors while Psychodynamic therapies explore intra-psychic processes and their interplay with interpersonal relationships. Family System therapies view the family as an emotional unit and examines the feedback loop between each individual in the family and the family as a whole. Although the research suggests that these and other treatment approaches can be helpful, please note that therapy may be a challenging process and no outcome can be guaranteed. You may not feel better or happier and disruptions to relationships may take place. Your therapist is available to discuss these issues, including therapeutic approaches, at any time during your treatment.

PAYMENT & FEES: Payment is expected for services at the time they are rendered, unless other arrangements have been made. Services are rendered and charged to the client, not to the insurance company. **Payments are made by credit/debit cards only**. Upon request, your therapist will provide you with a receipt to submit to your insurance company for reimbursement. You may also incur charges for phone calls lasting more than 15 minutes, letters and testing fees. Your fee may be subject to an annual increase. Fees for any extra time required by the therapist for legal proceedings will be charged at a higher rate than session fees. If you do not pay your fee, we are legally permitted to contact a collection agency.

I, the client, agree to be responsible for the payment of $_____ per session (45 minutes) which is payable at the time of the session (credit or debit card only). I understand that I am responsible for full payment, even though I may be reimbursed by my insurance company.

Client Initials _____

LIMITS ON CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and protected by law. Your therapist may not reveal any information to anyone without written permission by all parties, except where disclosure is required by law. In most situations, your therapist can only release information about your treatment if you sign a written Authorization Form. **However, your therapist is permitted or required to disclose information without either your consent or authorization under the following circumstances**:

- **ABUSE:** Your therapist is legally mandated to report any incident that leads to a reasonable suspicion of abuse or neglect of any individual that is under the age of 18, that is over the age of 65, or that is physically or intellectually dependent on another person. Child abuse also includes, but is not limited to, persuading a minor into any kind of obscene sexual conduct or the creation, distribution, or accessing of imagery depicting a minor in any kind of obscene sexual conduct.
- **SAFETY THREAT:** If you communicate a serious intent of significant physical harm toward yourself or an identifiable victim, your therapist must make reasonable efforts to prevent that harm. Additionally, if your therapist receives information that you communicated a serious intent of physical harm toward yourself or identifiable victim from a family member or significant other, your therapist must make reasonable efforts to prevent that harm as well. Reasonable efforts to prevent harm may include releasing information to the potential victim(s), your family members, and/or law enforcement.

- **CONSULTATION:** Your therapist may seek advice from other professionals. During a consultation, he or she will make every effort to avoid revealing the identity of any client. The other professionals are also legally bound to keep the information confidential. Your therapist may or may not discuss these consultations with you.
- **GOVERNMENT AGENCIES:** If a government agency is requesting the information for health oversight activities pursuant to their legal authority, your therapist may be required to provide it to them.
- **LAWSUITS:** If a client files a lawsuit or a complaint with a governmental agency that tenders his or her mental condition, or is involved in certain family law disputes, the psychotherapist-patient privilege may be waived and the therapist may be required to provide records or testimony. You should consult with your attorney about the possible impact of such litigation on the psychotherapist-patient privilege. If there is a complaint or suit by the client against the therapist, the privilege will be waived.
- **ADMINISTRATIVE STAFF:** Your therapist may need to share protected information with the administrative staff for administrative purposes, such as scheduling, billing, and quality assurance. Staff members have been given training about protecting your privacy and know not to release any information outside of the practice without the direction from a professional staff member.
- **SECURITY POLICY REGARDING ELECTRONIC INFORMATION:** Electronic transmission and storage of confidential information always entails security risks. It is our general policy to use it for scheduling purposes only to the greatest degree possible.

PARENTS AND CLIENTS WHO ARE MINORS: A client over 12 years of age may independently consent to psychological services if he or she is mature enough to participate in such services, or the minor would present a danger to him or herself, or others, or is the alleged victim of incest or child abuse.

- Clients over 12 years of age may independently consent to alcohol and drug treatment in some circumstances.
- Non-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records, unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or have a negative effect on the minor client's physical safety or psychological well-being.
- It is our policy to request an agreement between minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment the therapist will provide parents with only general information about the progress of the treatment, and a record of client's attendance at scheduled sessions. Therapists will encourage parent participation when appropriate.

PRE-LICENSED THERAPISTS:

I understand that my therapist is a: ❑MFT Trainee ❑Registered Associate MFT ❑Registered Associate PCC ❑Doctoral Student ❑Registered Psychological Assistant and, therefore, is not licensed, but is functioning under supervision by a licensed professional. I acknowledge that my treatment will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to treatment records.

_____ _____ _____ working under the direct supervision of

Therapist name Degree Registration number

_____ _____ _____ , have my permission to audio/video-

Supervisor name Degree License number

tape counseling sessions to be used for supervision purposes. I understand that my sessions will be taped as needed, will be used only for supervision purposes, and will be erased as soon as this purpose is fulfilled.

Client Initials _____

TERMINATION OF THERAPY: It is within the client's right to terminate therapy at any time. The therapist may choose to terminate therapy if the client is threatening or abusive to the therapist, not complying with the treatment plan, not paying for services, or if the therapist believes the client is no longer benefiting from the therapy. In the event of termination, the therapist will try to provide the client with several referrals, unless the client has already obtained other services or declines to get referrals. It is usually advisable, but not required, to have a termination session to process the work.

This is the entire agreement between the parties and cannot be changed except in writing by both parties. **Your signature below indicates that you have read this agreement and agree to its terms.** Please feel free to discuss any concerns you may have with your therapist or our Director of Clinical Services at 714-558-9266.

_____ _____ _____

Client Signature Client Name (Please Print) Date

_____ _____ _____

Client Representative Signature (If Rep., Print Name & Relationship to Client) Date

PERSONAL DATA (2)

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date _____ **Referred By** _____

Client: Name _____ Gender _____

Address_____ City_____ Zip Code_____

Primary Phone # (_____)_____ Email: _____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

Person to notify in case of emergency_____Relationship_____

Phone number_____

NOTE: It is important for the client and therapist to determine together what part of spiritual/religious issues will or will not take place in therapy.

Would you like spirituality/religious issues to be a part of your therapy? Y ❑ N ❑ Don't Know ❑

Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting *Extremely Serious*

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $ _____ per session which is payable at the time of the session.

Client Signature _____

Therapist Initials _____ **(over)**

FAMILY INFORMATION

Marital status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Parents: Father: Age _____ Occupation_____ Mother: Age _____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

Sibling(s): Age(s) _____ **Spouse/Partner:** Age _____ Occupation_____

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you experienced or witnessed Domestic Violence? Y ❑ N ❑ **Have you experienced a traumatic head injury**? Y ❑ N ❑

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y ❑ N ❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Height_____ Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

Are you currently covered by Medicare? Y ❑ N ❑

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hear/See things that others don't see/hear	❑	❑	❑	❑

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

CONSENT TO TREATMENT (2)

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_____ _____ _____ working under the direct supervision of

Therapist name Degree Registration number

_____ _____ _____ , have my permission to audio/video-

Supervisor name Degree License number

tape counseling sessions to be used for supervision purposes. I understand that my sessions will be taped as needed, will be used only for supervision purposes, and will be erased as soon as this purpose is fulfilled.

Client Initials _____

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This is the entire agreement between the parties and cannot be changed except in writing by both parties. **Your signature below indicates that you have read this agreement and agree to its terms.** Please feel free to discuss any concerns you may have with your therapist or our Director of Clinical Services at 714-558-9266.

_____ _____ _____

Client Signature Client Name (Please Print) Date

_____ _____ _____

Client Representative Signature (If Rep., Print Name & Relationship to Client) Date