Patient Introduction Forms

Adult

Please answer each item carefully and completely. All information on this form is confidential and will <u>not</u> be released without your prior written approval.

Your Full Name:_____Birth Date: ____/____/____Age____Sex_____

Home Address:_____
(Street) (City) (State) (ZIP)

Home Phone #: (_____)_____Work Phone #: (_____)_____

Email:_____SSN#: _____

Occupation: _____ Current Position: _____Dlic.#: _____

Employed by: _____ How Long? _____

Work Address: _____
(Street) (City) (State) (Zip)

Briefly Describe your reason for seeking help: _____

_____

_____

_____

Have you ever had any type of outpatient psychological assistance (counseling, therapy, etc.) in the past?
YES_____ NO _____

If yes, what was the reason for seeking assistance? _____

_____

_____

Duration of Treatment:_____

Have you ever had any type of inpatient care for mental/ emotional difficulties in the past? YES_____ NO_____

If yes, what was the reason for seeking assistance? _____

_____

_____

Describe any major changes in your life in the past two years:

_____

_____

_____

Please <u>circle</u> any of the following areas in which you are having difficulty:

Depression	**Anxious**	**Shyness**	**Sexual Problems**	**Parenting**
Boredom	**Suicidal Thoughts**	**Drug Use**	**Alcohol Use**	**Isolation**
Stress	**Friends**	**Anger**	**Self-control**	**Unhappiness**
Chronic Pain	**Marriage**	**Dating Skills**	**Divorce**	**Health Problems**
Sleep	**Headaches**	**Social Skills**	**Memory**	**Assertiveness**
Energy	**Education**	**Loneliness**	**Self-esteem**	**Concentration**
Nervousness	**Family**	**Relationships**	**Career**	**Legal Matters**
Nightmares	**Eating Problems**	**Perfectionism**	**Digestive Problems**	**Making Decisions**
Irritability	**Mood Swings**	**Others**_____		

List all medication you are now taking. Prescriptions (including birth control pills) and nonprescription (such as aspirin, allergy medication, etc.)

<u>Medication</u>	**<u>Dosage (amount & times per day)</u>**	**<u>Reason</u>**
1._____		
2._____		
3._____		

Name of Physician:_____

Address:_____

Phone:_____ **Fax:**_____

Date of last visit:_____**Reason for Visit:**_____

List any health problems:_____

_____

May I contact your doctor in order to consult? (Circle one) YES NO

If yes, please sign and date:_____**Date**_____

Do you smoke (circle one): YES NO If yes, how much?_____

Do you drink caffeinated drinks (coffee, tea, soda)? (circle one) YES NO

If yes, how much? _____

Do you drink alcoholic beverages? (circle one) YES NO

If yes, describe average intake: _____

Do you exercise regularly? (circle one) YES NO

If yes, please specify type of exercise: _____

List the people currently living in your home:

Name	Age	Relationship	Occupation

In case of emergency notify:

Name:_____Relationship:_____

Address:_____
(Street) (City) (State) (Zip)

Daytime Phone:_____Evening Phone:_____

Whom may I thank for this referral?:_____

Ginger A. Houseman, MA, MFT
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Newport Beach, CA 92660
949.584-2581

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Informed Consent for Treatment

PLEASE READ CAREFULLY AND INITIAL THE FOLLOWING:

CONFIDENTIALITY

_____ Your communication with a therapist are confidential. The information you share in therapy will not be communicated to others without your consent except where disclosure is required by law. Disclosure may be required in the following circumstances: (1) Reasonable suspicion of child, elder, or dependent abuse; (2) Where there is a reasonable suspicion that the patient presents a danger of violence to others; or (3) where the patient is likely to harm him/ herself unless protective measures are taken. In such instances, the confidentiality does not prevail since for the therapist to do nothing would endanger the patient's life and/ or the welfare of another. Disclosure may also be required pursuant to a legal proceeding.

_____ In the event the therapist has an individual contact with a client (where more than one patient has already been seen together) and information is told to the therapist that materially affects the therapy, this information may need to be shared.

CONSENT FOR TREATMENT

_____ I consent to the therapy which my therapist deems advisable or necessary in the treatment of my case. I understand the treatment planning and procedures are agreed upon mutually between the therapist and myself.

FINANCIAL AGREEMENT

_____ I understand that the fee for service is per each 50 minute hour. I agree to this fee and assume the responsibility for full payment. I understand that the fee structure will be reviewed once a year at which time fees may be increased; however, not more than $10.00 over the current fee, and I will be notified at least one month in advance. If this fee creates a financial hardship, I am free to discuss it with my therapist.

_____ I understand that payment is expected at the time of service. Please have payment ready at the beginning of the hour. Thank you!

_____ In the case that a check is returned because of insufficient funds, a **$25.00** processing fee will be charged.

_____ I understand that cancellation **must be 48 hours** prior to the *beginning* of the scheduled session or the full fee will be charged. The scheduling of an appointment does involve the reservation of time specifically for the client.

_____ In the event litigation becomes necessary for the collection of fees owed, I agree to pay such costs in addition to the fees owed, including, but not limited to, the reasonable fees of an attorney.

_____ The therapist will provide a generic form that the patient can use to bill his/her insurance company for direct reimbursement. This form will be provided as often (weekly, monthly, etc.) as the client wishes.

I HAVE READ AND AGREE TO THE ABOVE POLICIES.

Signature:_____ Date:_____

Signature: _____ Date: _____