Pathways to Wellness
A Southern California Relationship Center
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CLIENT INFORMATION FORM

Today's Date: _____

(Please print)

Name: _____Date of Birth: ____/____/_____ Age: _____

Address: _____ SSN: _____-_____-_____

City: _____ State: _____ Zip: _____

Home: (_____) _____ Work: (_____) _____ Fax: (_____) _____

Cell: (_____) _____ Do you have/use Text Messaging: __yes __no __what?_____

Email: _____

Occupation: _____ Employer: _____

Education/Degrees: _____ Student: ____Yes ___No Military: _____

Primary Care Physician: _____ Phone: _____

Relationship Status: _____Single _____Married/Partnership ____Separated ____Divorced ____Widowed

Spouse/Life Partner Name: _____

Emergency Contact: _____
Name Relationship Phone Number

OFFICE POLICIES:

Fees:

Individual Therapy: General session fees are $175 for 50-55-minutes.*

Couples Therapy: Initial intake sessions are $350 (which includes the session, questionnaire administration and clinician review of completed questionnaires); subsequent sessions are $185 for up to 60 minutes.*

Dr. Nancy's fees: Initial intake sessions are 75-80 minutes at $500 (which includes the session, questionnaire administration and clinician review of completed questionnaires). General session fees are 75-80 minutes at $300.

Sessions lasting longer than 60 minutes will be charged at the appropriate fraction of time at $175.00 per hour ($185 for couples). It is important to note that additional time and phone therapy is often NOT covered by insurance and is the sole responsibility of the client.

Communication outside of sessions, site visits, report writing and reading, consultation with other professionals, release of information, reading records, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise.

Payment for Services: Payment of fees MUST be made in full at the time services are rendered unless prior arrangements have been made. A minimum $30.00 service charge will be made for any checks which are returned by the bank.

Insurance Reimbursement: We are OUT-OF-NETWORK for all insurance providers. We do accept Medicare with supplemental insurance. We do not accept HMO plans. Clients who carry insurance should remember that professional services are rendered, charged to, and paid for by the client and not the insurance company. Any billing we do for the client is as a courtesy and can only be done through PPO/POS plans with OUT-OF-NETWORK coverage. A "superbill" receipt can be provided to you, which can be sent to your insurance company for reimbursement.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48-hour notice is required for rescheduling or cancellation of appointments. The full fee will be charged for missed sessions without such notification. Clients who miss appointments and fail to inform the office 48 hours prior, are required to pay for missed sessions and for future sessions in advance in order to secure desired appointments.

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child or elder abuse; where there is a reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm her/himself unless protective measures are taken. Disclosures may also be required pursuant to a legal proceeding. Psychology, Associate Clinical Social Worker, and Associate Marriage and Family Therapy interns are supervised by Nancy D. Young, Ph.D. a licensed clinical psychologist, who will have access to your confidential records and information for the purposes of supervision and quality assurance.

Emergency procedure: If an emergency arises and you need immediate assistance, PLEASE CALL 911.
If you need to contact your clinician between sessions, please leave a message on her/his confidential Voice Mail or via email.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES. I AGREE TO THE ABOVE PROVISIONS. I AUTHORIZE TREATMENT AND AGREE THAT I (CLIENT) AM RESPONSIBLE FOR ANY AND ALL CHARGES.

Signed: _____Date: _____

1. How did you hear/learn about Pathways to Wellness? _____

2. Please describe your reason(s) for seeking counseling at this time (Include date or month/year problem began).

_____

_____

3. Was there an event which made these issues/problems surface? ___Yes ___No

If yes, please describe: _____

_____

_____

4. What result(s) do you expect from counseling?

_____

_____

5. Previous experience with therapy:

Your age or year at start	How long?	What for?	Type of Therapy (if known)	most helpful thing about it for you	Least helpful thing
Example: 25	*4 years*	*depression after parents died in terrible car crash*	*cognitive behavioral, EMDR, grief*	*learning about grief and trauma*	*sometimes would ask me things that seemed unrelated*
Example: 2001	*2 years*	*unhappy in marriage*	*Gottman Marital Therapy, Emotion Focused Therapy*	*learning new skills for my marriage*	*it went well, no complaints*

Family:

1. Who lives with you in your home?

Name	Relationship	Age	Occupation

2. Marriage or relationship history:

Spouse/Significant other Name	YOUR age at Start of Relationship	Their Age at Start	Year Relationship Started	Year Divorced (D) Separated (S) Widowed (W)	Reason Relationship Ended (if applies)
Example: Jim	*24*	*23*	*1971*	*D 1975*	*I was unfaithful*

3. Children---Please indicate which are from current, previous marriage/relationship(s), or step.

Name	Age	Gender	Grade in School	Any Adjustment problems	Relation: Current/Previous/Step

4. Briefly describe past and present relationship(s) with the following. How does it feel to be in these relationships?

Marital: _____

_____

Children: _____

_____

Parents: _____

_____

Siblings: _____

_____

History of Problem Areas:

1. Please indicate if you are experiencing any problems in the following areas:

Sexual Problems __Yes __No Chemical/Alcohol Abuse __Yes __No

Physical Abuse __Yes __No Incest/Molestation Issues __Yes __No

Gambling Issues __Yes __No Repetitive/Compulsive Behavior __Yes __No

2. Have you ever used, or do you currently use any of the following?

Substance:	Past	Present	Substance:	Past	Present
Alcohol	___	___	LSD	___	___
Amphetamines/Speed	___	___	Marijuana	___	___
Barbiturates/Downers	___	___	Pain Killers	___	___
Caffeine	___	___	PCP	___	___
Cocaine	___	___	Tobacco/Nicotine	___	___
Crack	___	___	Tranquilizers	___	___
Heroin	___	___	Other: _____	___	___

3. Please indicate and rate the severity (1-4) of the following issues or problems you would like to work on in treatment.

No Problem 1 | Mild Problem 2 | Moderate Problem 3 | Severe Problem 4

__Depression
__Lack of Friends
__Marriage/Relationship Issues
__Ability to concentrate
__Anxiety/Nervousness
__Loneliness
__Sexuality/Sexual Issues
__Ability to control your anger
__Controlling stress
__ Problems coping
__Family Conflicts
__Loss of a loved one
__Abuse/victimization
__Behavioral Problems
__Spirituality issues
__Problems at School
__Financial Problems
__Eliminating a drug/alcohol problem
__Mood problems
__Legal matters
__Eating habits
__Sleeping habits
__Eliminating another problem (i.e. overspending, gambling, etc.)

4. Other—please list any other issues/concerns not listed above—and rate the issues/concerns in the same manner:

_____

_____

5. Please list any prescription medication you have used in the last few years or are currently using including dosage:

Medication	Dosage	Frequency	Past/ Present	Prescribing Physician
EXAMPLE: Zoloft	*200mg*	*Daily*	*present*	*Dr. Gracie Lou 949-555-7144*
EXAMPLE: Effexor	*150mg*	*don't recall*	*past*	*Dr. Fred George 562-555-9477*

6. Please list any over the counter medications/herbs including dosage you **currently** use such as vitamins, sleeping pills, diet pills, sinus or allergy remedies, aspirin/pain relievers, etc.

_____

_____

_____

7. Current Exercise—Types and Frequency

_____

_____

_____

8. What major illnesses, injuries, accidents, traumas, allergies, or hospitalizations have you experienced in the past?

_____

_____

_____

9. Do you experience any of the following? (Please check all that apply)

__Trouble sleeping	__Convulsions	__Allergies to foods or medications
__Double or poor vision	__Paralysis	__Indigestion, gas, heartburn
__Difficulty hearing	__Dizziness	__Unusual excessive thirsty/dry mouth
__Fainting	__Stomach pain	__Diarrhea or constipation
__Black outs	__Headaches	__Vomiting/vomiting blood
__Thyroid Problems	__Chest pains	__Blood in stool
__Coughing or wheezing	__Palpitations	__Change in appetite or eating habits
__Shortness of breath	__Joint pain	__Sexual problems
__Swelling of hands or feet	__Weakness or tiredness	__Difficulty with Urination (lack of, burning, etc)

__HIV/AIDS Diagnosis ___Problems w/memory/thinking/concentration/attention

__ Hepatitis Diagnosis ___Weight gain or loss—(Please Circle) # of pounds ____ Time period ___

__Seizures __Lumps/rashes anywhere on body—Specify location _____

10. What involvement with police, courts, jails, and prisons have you had, include any open charges?

_____

_____

11. Do you have any other legal involvements in the present?

_____

12. How many hours do you spend a week at work? _____

13. How satisfied are you with your current work situation, compensation, work stress, and work relationships?

_____

_____

14. What do you do to take care of yourself emotionally and physically, and/or to reduce/manage stress?

_____

_____

15. How many jobs have you had in the past five years? Please state your reason for termination.

_____

_____

_____

16. Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e. gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness related, thoughts of harming someone, use or fear of obscene language, etc.) ___Yes ___No
If yes, please describe: _____

_____

17. What are your personal strengths?

_____

_____

18. What would you like to change about yourself?

_____

_____

19. In your life, what do you feel has been missing and/or interfering with your happiness or success?

_____

_____

_____

20. Have you ever thought of killing yourself? (If yes—please state when, and discuss what brought you to the attempt and how you were able to keep from doing it? What kept you alive?)

_____

_____

_____

21. Is there anything else you would like to share at this time or other areas you would like to focus on?

_____

_____

_____