
Client Information Sheet

Name: _____ Spouse/Partner: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____ May I text you? _____

Employer: _____ Position: _____

Work Phone: _____ How long worked there? _____

Education: Last grade/degree completed _____ Vocational Training: _____

Responsible Party Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____ May I contact who referred you? _____

Family Physician: _____ Phone: _____

Family/Household Members (include name, relationship, and age)

Reason for Appointment: _____

Previous Therapy (List Therapist's name(s) and approximate dates)

I CONSENT TO TREATMENT WITH Matthew T. Harris, MSSW, LMFT

Signature: _____

Date: _____

Client Name: _____

Informed Consent

Part I: Your Rights as Client(s)

- You have the right to ask questions about any procedures used during therapy; if you wish, I explain my approach and methods to you. If I see a child under the age of consent, parents have a right to information shared in the session, to the extent allowed by KY law. Parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and the therapist.
- You have the right to decide not to receive therapy from me; if you wish, I will provide you with the names and contact information of three other qualified therapists in the area.
- You have the right to end therapy at any time, without obligation other than financial fees already accrued. I ask that you contact me by phone if you make such a decision without consulting me.
- You have a right to review your records in the files. Generally, parents have the right to consult with their child's therapist concerning their child's treatment and progress, and to inspect the child's file, to the extent allowed by KY law.
- One of the most important rights involves **confidentiality**: Within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the couple or family as a whole as the client. Therefore, releases of information for couple or family sessions require the written approval of every consenting member of the couple or family who was present at any time during the treatment.
- If you request it, any part of your record in the files can be released to any person or agency you designate with your signed permission. I will tell you at the time whether or not I think releasing the information might be harmful in any way to you.
- You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations are as follows: (a) if you threaten to harm yourself or another person, I am required by law to report this to the appropriate authority; (b) if a court of law issues a legitimate court order, I am required by law to provide the information specifically described in that order; (c) if you are in therapy by order of a court of law, information concerning your attendance and results to treatment must be revealed to the court; and (d) if you reveal information relative to child or dependent person neglect or abuse, or elder or spouse abuse, I am required by law to report this to the appropriate authority.
- You have a right to know the potential risks and benefits of therapy. The risks include: possible denial of insurability when applying for medical and disability insurance, due to a DSM V or ICD-10 diagnosis, which are usually required for reimbursement under medical insurance; possible repercussions in situations that require disclosure of treatment for mental disorders, such as some driver's license applications, concealed weapon permits, and security clearances and job applications; also, clients may temporarily experience intense and/or uncomfortable feelings when discussing the situations that brought them to therapy, or experience relationship changes that may not be originally intended. The benefits of therapy include: reduction in symptoms and/or resolution of problems and concerns brought to therapy; a better ability to handle or cope with couple, family, or other interpersonal relationships; and a greater understanding of personal and family goals and values that may lead to improved functioning and happiness as an individual and increased relational harmony.

Client Name: _____

Part II: The Therapeutic Process

- Therapy will seek to meet the goals established by all persons involved, usually revolving around a specific presenting problem, but there is no guarantee that these goals will be met. In working to have the best chance of achieving these goals, clients must firmly commit to attendance and active participation in therapy. With client input and collaboration, I will assess client strengths, needs, supports, symptoms, and possible diagnoses (if appropriate) and barriers to goal attainment; help to identify and clarify goals for therapy, generate a treatment plan with interventions to address goals, and help clients monitor progress toward goal attainment and termination of sessions.

Part III: Fees and Length of Therapy

- Individual therapy sessions are 60 minutes. Couple and family therapy sessions are 60 minutes in length. The number of sessions may depend on the goal(s) to be addressed, the severity of problems, and progress toward goals.
 1. *I agree to enter into therapy with Matthew T. Harris, MSSW, LMFT. I agree to pay ___\$120.00___ for the initial session and ___\$80.00___ for each subsequent session. Full payment is due at the end of each session in the form of cash, check, or credit card (subject to a 2.75% processing fee), and no balance will be carried.*
 2. *I understand that I can leave therapy at any time, and that I am contracting to pay only for completed therapy sessions.*
 3. *A **24-hour notice** is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the full session fee. I understand that this will be my responsibility.*
 4. *I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed to ensure confidentiality.*

Client: _____

Date: _____

Client Child Name(s) _____

Date: _____

Therapist: _____

Date: _____

Symptom Inventory & Treatment History

Name: _____

Person Completing Form (if different): _____

Age: _____ Gender: _____

Relationship Status (circle one):

Single (never married)	Cohabiting (living together)	Significant Other
First Marriage	Remarried (after spouse's death)	Divorced
Separated	Remarried (after divorce)	Widowed

Occupation: _____

Place of Employment: _____

Children:

_____ Name	_____ Age	_____ Living at Home
_____ Name	_____ Age	_____ Living at Home
_____ Name	_____ Age	_____ Living at Home
_____ Name	_____ Age	_____ Living at Home
_____ Name	_____ Age	_____ Living at Home

Are you currently taking any prescription medications? Y N

Please List (with reason for taking): _____

Name(s) of Prescribing Physician: _____

Medical History/Diagnoses: _____

Family history of substance abuse or mental health problems? _____

Referral Source/How you heard about me: _____

Reason for seeking therapy: _____

Goals for Treatment: _____

Any other information you would like your therapist to know? _____

Please rate the severity of the following symptoms **over the last month** according to the following rating scale:

0 - No Difficulty

1 - Mild

2 - Moderate

3 - Severe

- | | |
|--|--------------------------------------|
| _____ Decreased Appetite | _____ Sexual Identity Uncertainty |
| _____ Increased Appetite | _____ Gender Dysphoria |
| _____ Bingeing and/or Purging | _____ Nightmares |
| _____ Weight Change? +/- _____ lbs. | _____ Hypervigilance |
| _____ Depressed Mood | _____ Obsessive Thoughts |
| _____ Decreased Energy/ Fatigue | _____ Compulsions |
| _____ Trouble Falling/Staying Asleep | _____ Spending Sprees |
| _____ Trouble Waking Up | _____ Racing Thoughts |
| _____ Decreased Sexual Desire | _____ Rapid Heart Beat |
| _____ Difficulty with Sexual Functioning | _____ Trouble Breathing |
| _____ Loss of Interest in Activities | _____ Sweating |
| _____ Crying | _____ Phobia |
| _____ Feelings of Hopelessness | _____ Police/Probation Involvement |
| _____ Feelings of Helplessness | _____ Stealing |
| _____ Decreased Attention Span | _____ Lying |
| _____ Inattentive/Distractible | _____ Truancy |
| _____ Memory Problems | _____ Violent Behavior Toward Others |
| _____ Self-Injurious Behavior | _____ Destruction of Property |
| _____ Thoughts of Suicide | _____ Harming Animals |
| _____ Thoughts of Harming Others | _____ Fire Setting |
| _____ Impulsivity | _____ Opposition |
| _____ Hyperactivity | _____ Anger Outbursts |
| _____ Anxiety/Nervousness | _____ Irritability |
| _____ Worry/Fear | _____ Fear of Being Abandoned |
| _____ Flashback of Traumatic Event | _____ Feeling Abandoned/Alone |