Client Information Sheet

Name: _____ Spouse/Partner: _____

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

Date of Birth: _____ Phone: _____ May I Text You? _____

Email: _____

Employer: _____ Position: _____

Work Phone: _____ How long worked there? _____

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

Emergency Contact 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 they 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 _____$150.00_____ for the initial session and _____$100.00_____ 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. If I do not contact my therapist within 48 hours of a missed appointment, all subsequent appointments will be cancelled.*
4. *Any letters/recommendations written to other providers/professionals will be charged $30.00.*
5. *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)	Cohabitating (living together)	Significant Other
First Marriage	Remarried (after spouse's death)	Divorced
Separated	Remarried (after divorce)	Widowed

Length of Relationship: _____

Occupation: _____

Place of Employment: _____

Children:

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
_____ Increased Appetite
_____ Bingeing and/or Purging
_____ Weight Change? +/- _____lbs.
_____ Depressed Mood
_____ Decreased Energy/ Fatigue
_____ Trouble Falling/Staying Asleep
_____ Trouble Waking Up
_____ Decreased Sexual Desire
_____ Difficulty with Sexual Functioning
_____ Loss of Interest in Activities
_____ Crying
_____ Feelings of Hopelessness
_____ Feelings of Helplessness
_____ Decreased Attention Span
_____ Inattentive/Distractible
_____ Memory Problems
_____ Self-Injurious Behavior
_____ Thoughts of Suicide
_____ Thoughts of Harming Others
_____ Impulsivity
_____ Hyperactivity
_____ Anxiety/Nervousness
_____ Worry/Fear
_____ Flashback of Traumatic Event

_____ Sexual Identity Uncertainty
_____ Gender Dysphoria
_____ Nightmares
_____ Hypervigilance
_____ Obsessive Thoughts
_____Compulsions
_____Spending Sprees
_____ Racing Thoughts
_____ Rapid Heart Beat
_____ Trouble Breathing
_____ Sweating
_____ Phobia
_____ Police/Probation Involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent Behavior Toward Others
_____ Destruction of Property
_____ Harming Animals
_____ Fire Setting
_____ Opposition
_____ Anger Outbursts
_____ Irritability
_____ Fear of Being Abandoned
_____ Feeling Abandoned/Alone