CLIENT INFORMATION

Please fill out this form and bring it to your first session. Please note that the information you provide here is protected as confidential information.

DATE _____

Client Name:_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Current Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____) _____ May I leave a message? □Yes □No
Cell/Other Phone: (_____) _____ May I leave a message? □Yes □No
Work Phone: (_____) _____ May I leave a message? □Yes □No
E-mail: _____ May I email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

School Status: □ Full Time □ Part Time □ High School □ College □ Trade School □ Other

Referred by (or how did you hear about New Life MFT, Inc. or Mr. Doug Garner, MA, LMFT):
_____

_____

What prompted you to choose New Life MFT, Inc. and Mr. Doug Garner:
_____

_____

Name of parent (if client is under 18 years old):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Parent signature: _____

Please list children/age _____
_____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No
□ Yes, previous therapist/practitioner: _____

Last Physical Exam (Date) ____/____/____ Name of PCP: _____

Please list any prescription medication and dosage you are currently taking?
_____
_____

Have you ever been prescribed psychiatric medications □ Yes □ No

Please list and provide dates: _____
_____

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the client, and on the client's behalf I Legally authorize Doug Garner, MA, LMFT to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent.

Name of guardian/legal representative:
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Signature of Guardian/Legal Representative _____

If a Child is under Conjoint Legal Custody then both Parents need to consent to treatment:
Name of guardian/legal representative:
_____
(Last) (First) (Middle Initial)
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Phone #: _____ Address: _____

Signature of Guardian/Legal Representative _____
(Written or Verbal Consent with Doug Garner, MA, LMFT)

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____
_____
_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Existing Condition	Please Circle One	List Family Member
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
ADD or ADHD	Yes / No	
Bipolar	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorder	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Disorder	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, where are you employed: _____

_____

If yes, what is your current employment situation: □ Full Time □ Part Time □ Laid Off

□ Medical Leave (Stress or Injured) □ Other (explain): _____

Do you enjoy your work? □ No □ Yes
Is there anything stressful about your current work? _____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths? _____

_____

4. What do you consider to be some of your weaknesses? _____

_____

5. What would you like to accomplish out of your time in therapy? My Goals are:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Emergency Access

Doug Garner can be reached after hours to handle urgent matters; medical emergencies must be handled by calling 911 or going directly to a Hospital's emergency room. Doug Garner's 24 hour cell phone number is **(661) 317-2492**. You phone call will return your call as soon as possible.

The normal amount of time for urgent phone calls is 5 – 10 minutes, calls lasting 15 minutes or longer will be charged for each 15 minute increments. When Mr. Garner is on vacation, special arrangements will be made for another therapist to accept urgent calls.

Consent for Treatment

I authorize and request my practitioner, Doug Garner, to carry out psychological exams, treatment, and/or diagnostic procedures. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process *can* bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Please Sign and Date Below

_____

Client/Parent/Guardian/Legal Representative **Date**

Financial Terms: Insurance Coverage and Co-payments

The Charge, deductibles and Copayments

The Cost of The First Session is $80 and $70 for each additional session, unless your insurance company or EAP Company has a contracted rate.

Each session is 45 minutes in length.

You are responsible for obtaining prior authorization for treatment from your insurance carrier. *You are ultimately responsible for 100% of your bill.*

New Life MFT, Inc. will bill your insurance company. In the event you're insurance company does not pay its expected amount, that amount will be transferred to the clients account and the client will be expected to pay the full session fee.

It will be you're responsible to meet any make deductibles and make co-payment and, if any, as set forth by your benefit plan. Most co-payment amounts are set by your benefit plan.

Copayments and applicable deductibles are **due and payable at the beginning of each therapy appointment**. The co-payment set by your plan, if known, for each visit is as follows:

For each appointment the co-payment/payment will be $_____; or _____

If possible this practitioner will inform you of costs when you are beyond or outside your benefits. At any time during treatment should you become ineligible for insurance coverage, you will need to notify the practitioner and be aware that you become responsible for 100% fee for each session.

Additional Charges

Additional Charges include letters or reports for whatever reason (School, Court, Lawyer, DCFS or for any other reasons) are charged at a rate of *$75.00 per* letter.

Late Fee

There is A *LATE FEE CHARGE OF* ***$20*** *FOR EACH MONTH*, if not paid the month of receiving a statement, for the arrears portions of outstanding balances owed by the client

IF THE OUTSTANDING BALANCE IS NOT PAID IN FULL AFTER 2 MONTHS YOUR BILL WILL BE SENT TO **COLLECTIONS**.
THIS OFFICE ONLY SENDS STATEMENTS AND WILL NOT CALL YOU.

SYMPTOM CHECK LIST

Please place an "X" under the severity of each symptom you are experiencing.
Also, please indication the **duration** of symptoms in terms of weeks, months or years (e.g. 2 months)

	None	Mild	Moderate	Severe	For how long?
Work Related Problems (Circle): Co-workers	Management		Tardiness		Job Functioning
Couple/Marital Problems					
Parent – Child Problems					
Academic Failure					
Aggressive Behavior					
Anger Control Issue					
Anxiety					
Appetite Changes					
Authority Conflict					
Binging/Purging					
Bored Easily					
Compulsive Behavior					
Cruelty to Animals					
Depressed Mood					
Destructive Conduct/Destruction of Property					
Difficulty getting up in the Morning					
Difficulty Going to Sleep					
Difficulty Staying Asleep					
Difficulty with Concentration					
Dissociative Episodes (Loss of Time)					
Easily Distracted					
Enuresis (bed wetting)					
Enuresis (soiling clothing)					
Excessive Daydreaming					
Extremely Bossy Behavior					
Fearfulness					
Feelings of Grief or Loss					
Feelings of Hopelessness					
Feelings of Paranoia					
Feelings of Powerlessness					
Fire Setting					
Homicidal Thoughts					
Hostility					
Hyper Focusing (Video Games or TV)					
Hyper sexuality					
Hyperactivity					
Impaired Judgment					
Impulsivity					
Inattentive					
Intrusive (Uncontrolled) Thoughts					
Irritation					

	None	Mild	Moderate	Severe	For how long?
Lack of Organization					
Lawbreaking					
Learning Disabilities					
Lethargy (Couch Potato)					
Little or no Remorse or Guilt					
Low Energy					
Low Self-Esteem					
Lying					
Manipulative Behavior					
Memory Problems Long Term					
Memory Problems Short Term					
Migraine Headaches					
Mood Elation (Overly Excited)					
Mood Swings					
Motor or Vocal Tics					
Negative Body Image					
Nightmares/ Night Terrors					
Obsessive Thoughts					
Often Losses or Misplaces Things					
Oppositional (Defiant) Behavior					
Over-Sensitive					
Panic Disorder					
Post Traumatic Stress Disorder					
Problems with Grooming					
Racing Thoughts					
Rages or Explosive Temper Tantrums					
Rapid Cycling of Moods (by hour, day, week)					
Restlessness/Fidgetiness (Could be internalized)					
Risk Taking Behaviors					
Running Away					
School Phobia					
School Truancy					
Self Mutilating (Cutting) Behaviors					
Separation Anxiety					
Silliness, giddiness and goofiness					
Somatic (Body) Complaints					
Stealing					
Stressed					
Suicidal Thoughts					
Temper Tantrums					
Tense					
Victim of Abuse (Physical, Sexual, Verbal)					
Violent					
Weight Gain/Weight Loss (Circle)					

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records, unless there certain circumstances that the release of confidential information may be harmful to the minor, as determined by the therapist, or the Court or Child's Attorney holds the Privilege.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that **may** be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Parent/Guardian/Legal Representative, if under 18)

Today's Date _____

CANCELLATION POLICY

If you fail to cancel a scheduled appointment a full 24 hours in advance, we cannot use this time for another client, because the scheduled time was specific for each client, therefore you will be billed for the entire cost of your missed appointment.

A full fee is charged for missed appointments, no show and cancellations with less than a full 24 hour notice.
A statement will be mailed directly for such charges..

Thank you for your consideration regarding this important matter.

_____

Client Signature (Parent/Guardian/Legal Representative, if under 18)

_____

Today's Date