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Confidential Client Information

Name:				**Today's Date:**		
Address:				**Date of Birth:**		Age:
City, State, Zip:				**S.S. Number:**		
Home Phone:				**Employer:**		
Cell Phone:				**Work Phone:**		
Fax Number:				**Job Title:**		
E-Mail:				**Time on Job:**		
Emerg. Contact:		Phone:		**Medical Issues:**		
Emerg. Contact:		Phone:				
Health Insurance:				**Physician:**		Phone:
Group Number:				**Psychiatrist:**		Phone:
Date of Coverage:				**Marital Status:**	Single	Dating
Therapy Goals:					Married	Separated
Strengths:					Domestic Partner	Divorced
					Non-Domestic Partner	Widowed
Previous Therapy:		Dates:		**Current Meds:**		
		Dates:				
		Dates:		**OTC / Herbal:**		
Psych. Hosp. Stay:		Dates:				
		Dates:		**Use of Alcohol:**	Type:	Freq:
Referred By:				**Use of Drugs:**	Type:	Freq:

Symptoms Experienced During Past Year

Anxiety	Elevated Mood	Increased Appetite	Depressed Mood	New Relationship
Panic Attacks	Racing Thoughts	Decreased Appetite	Frustration	Relationship Breakup
Difficulty Sleeping	Spending too Much	Increased Interest in Sex	Irritability	Relationship Conflict
Sleeping too Much	Increased Job Stress	Increased Use of Drugs	Fatigue	Family Conflict
Isolation from others	Suicidal Thoughts	Increased Use of Alcohol	Physical Illness	Sexual Problems
Increased Anger	Violent Behavior	Thoughts of Hurting Others	Feelings of Guilt	Death of Loved One

Recovering Alcoholic?		How Long?		**Recovering Drug Addict?**		How Long?	
Recovering from Eating Disorder?		How Long?		**Recovering Sexual Compulsive?**		How Long?	
Cultural or Ethnic Background:				**Auto License Plate #:**			
Current Religion or Spirituality:				**Highest Level of Education:**			
Family Religion:				**Degree Title or Major:**			

Family Members and Significant Others

Name:	Relationship	Current Age or Date of Death	Place Resides

Please use reverse for additional persons.

INFORMED CONSENT - PLEASE READ AND SIGN BELOW:

Fees: Your agreed upon appointment time is held specifically for you. As the client, you are responsible for payment of the fee at each session, unless other arrangements have been made in advance. Except in cases of emergency, you will be charged for appointments missed without notification and for appointments cancelled or changed without 24 hours notice. You will be responsible for payment of fees, including any claims submitted to an insurance company that are denied for any reason.

Confidentiality and safety: A. All matters discussed with the psychotherapist are confidential, except in any of the following circumstances, which are required or permitted by law: **1.** When the client gives written permission for the therapist to share specific information with others (e.g. physician or insurance company), **2.** When the therapist has reason to suspect that a child, elderly person, or dependent adult in the client's life has been physically, sexually, emotionally, or financially abused, **3.** If the therapist has reason to believe that the client intends to physically harm another person or persons, or **4.** If the therapist has reason to believe that the client is acutely suicidal, the therapist will take measures necessary to protect the client's safety, including breaking confidentiality. **B.** Threats of violence towards either party may lead to immediate termination of session, and to safety planning for the intended victim. **C.** Any extra-session communication shared with the therapist is subject to in-session exploration when both parties are next present, unless the secret might lead to harm for either party. **D.** The client understands the limitations of therapy, that there can be no guarantees of success, and that the client may occasionally experience discomfort or feel worse during the course of treatment. **E.** During the use of electronic communication, including but not limited to online video sessions or email, the client understands there may be increased limitations of client confidentiality. **F.** When using electronic communication for treatment, the client agrees to provide current information for local emergency contact and client location.

Consent for Treatment: I agree to be treated by Andrew Sears MA, LMFT, and to the conditions of treatment listed above

Client Signature: