

**NEW CLIENT INFORMATION/CONSENT FORM**

**Client Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone (May we call you at): Home?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell?**\_\_\_\_\_\_\_\_\_\_\_\_\_ **SMS/Text?** Y / N

**Relationship Status:**  Single \_\_\_ Married: Date \_\_\_\_\_\_\_ Separated/Divorced: Date \_\_\_\_\_\_\_ Widowed: Date \_\_\_\_\_\_\_
(Check one) Living together – Date \_\_\_\_\_\_\_\_ Partnered – Date \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pronoun(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**People living in home: name/age/relationship to you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer/School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Person to be contacted in case of emergency:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Presenting Problem (s): Please describe the reasons you are seeking counseling (include date the problem started):**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Medical History: Please list any prescription medications you currently use:**
NAME DOSAGE FREQUENCY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Please list any past or present conditions that you are of have been treated for:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**When did you last have a physical examination?**  \_\_\_\_\_\_\_\_\_\_ **Physician Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Psychiatric History:** Have you ever received psychological or psychiatric treatment of any kind before? [ ] Yes [ ] No

If you answered “Yes” to the above question, please answer the following:

What type of care did you receive? [ ] Inpatient (hospital) [ ] Outpatient [ ] Both

Dates you were in treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long was your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who was your therapist or doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you prescribed medicine at this time? [ ] Yes [ ] No [ ] Not applicable

If Yes, what was prescribed (include dosages if you know): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Please describe any significant emotional, medical, or chemical dependency conditions of your parents and/or other family members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Substance Use History:** Have you ever used drugs or alcohol? [ ] Yes [ ] No - If Yes, please describe:
Substance Amount Frequency When? (First and Last use)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever received substance abuse treatment of any kind before? [ ] Yes [ ] No
Do you have a history of blackouts, seizures, or withdrawal symptoms? [ ] Yes [ ] No

**Please describe anything else you’d like your clinician to know:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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 **Habits: Amount Currently Using Most Ever Used**

Coffee (cups/day) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Cigarettes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS from a scale of 1-5 using this scale:** (1) No Effect (2) Little Effect (3) Some Effect (4) Significant Effect (5) Extreme Effect

Marriage/Relationship \_\_\_\_ Family \_\_\_\_ Job/School Performance \_\_\_\_

Friendships \_\_\_\_ Enjoyment \_\_\_\_ Finances \_\_\_\_ Concentration \_\_\_\_

Physical Health \_\_\_\_ Anxiety \_\_\_\_ Depression \_\_\_\_ Mood \_\_\_\_

Sexual Functioning \_\_\_\_ Self-Confidence\_\_\_\_ Self-Care \_\_\_\_ Temper \_\_\_\_

Eating Habits \_\_\_\_ If eating habits are affected, describe how: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleeping Habits \_\_\_\_ If your sleeping habits are affected, describe how: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please initial each section, indicating you acknowledge the information you have read:**

**\_\_\_\_Confidentiality:** All information between counselor and client is held strictly confidential, unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected.
5. Other specific instances as outlined in state or federal law, or pursuant to a court order.

*In the latter three cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.*

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**\_\_\_\_Financial Terms:** The client is responsible for payment of psychotherapy services. Unless otherwise negotiated with therapist payment of services is due in full at the time of service. Payment arrangements should be made prior to your first visit. **Fee per visit is $90** **for 50 minutes, and $135 for 80 minutes**. This fee shall be paid in full at the time of appointment (for Health Insurance, see below\*) *Therapist reserves the right to increase fee with reasonable notification (at least 30 days).*

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**\_\_\_\_COVID-19:** The client is aware that there will be a COVID-19 screening prior to each in-person session for both therapist and client. This includes confirmation of travel outside of the state/country, experience of any COVID-19 symptoms in the past 48 hours, or exposure to someone who has experienced symptoms or tested positive for COVID-19.

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**\_\_\_\_Canceled/Missed Appointments:** A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee. A credit card will be placed on file to pay for the missed session.

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**INSURANCE INFORMATION:** Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_ Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Caldwell-Clark and its representatives are Out-of-Network Providers**. *The client shall pay fee in full each session*. Insurance forms will be prepared on a monthly basis. Caldwell-Clark deems no responsibility for the reimbursement of payment from the client’s insurance carrier. **It is the responsibility of the client to send in the forms and receive reimbursement from their insurance carrier**, **unless otherwise agreed upon.**

------------------------------------------------------------------------------------------------------------------------------------------------------- **\_\_\_\_Consent for Treatment:** I further authorize and request that Caldwell-Clark provide psychological treatment and/or diagnostic procedures, which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

------------------------------------------------------------------------------------------------------------------------------------------------------- **\_\_\_\_** The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

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**Confirmation of Acceptance to Terms:** I agree to all of the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client (or Parent/Guardian) Print Client (or Parent/Guardian) Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client (or Parent/Guardian) Print Client (or Parent/Guardian) Signature Date