Maureen Kaye, MFT

Marriage and Family Therapist
License # MFC 44834

Adult Client Intake

Date_____

Name_____ Age_____ Birth date _____
Address_____ City_____Zip_____
Occupation _____ Employer_____
Home Phone ( )_____ Work ( )_____ Cell/Pager( )_____
Is it O.K. to call you at home? _____ At work?_____ Cell? _____ May I identify myself/leave message? _____
Reason(s) for seeking therapy:_____
Who referred you to me? _____ May I thank them? Y N
Marital Status (Circle) S M D W Sep How Long?_____ Previous Marriage(s)?_____
Previous Counseling? Y N When_____ Duration_____Was it a good experience?_____
Have you ever been hospitalized for psychological treatment?_____When?_____Where_____
Are you currently under a physician's and/or psychiatrist's care?_____
M.D. & Phone_____
Medications Currently Taking (use back of page if needed)_____

Please indicate your highest level of education:
Some High School_____ H.S. Diploma____ Some College_____ College____ Degree____ Graduate Degree_____

SPOUSE/SIGNIFICANT OTHER INFORMATION:

Name_____Age_____ Birthdate_____
Address (if different than above)_____
Occupation_____ Employer_____ Address _____
Home Phone ( )_____ Work ( )_____ Cell ( )_____

CHILDREN:

Name _____ Birth date _____Name _____ Birth date _____
Name _____ Birth date _____Name _____ Birth date _____
Name _____ Birth date _____Name _____ Birth date _____

OTHERS LIVING IN HOME: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name _____ Phone _____ Relationship _____

Agreement for Psychotherapy Services

Because therapy often begins in a situation of considerable emotional difficulty, I have prepared these notes so that you will have an understanding of our basic agreement.

Client Name(s): _____Date:__ _____

Families Counseling Center is owned by Deborah Tucker, MFT, License # ML 17142.

This office is comprised of several psychotherapists who have joined together for advertising purposes. Each therapist's practice is separate and each is solely and entirely responsible for any liabilities resulting from that practice.

Although I am in an independent private practice, I work closely, whenever possible and appropriate, with my professional associates. I also utilize professional consultations in order to continually improve my professional skills. I meet regularly with my associates and other professionals for case management and consultation. These professionals must also abide by the ethical rules of confidentiality. I will assume I have your permission to discuss your case (not your name or other identifying information) with any of my colleagues. If this is not acceptable to you, please let me know.

The Process of Therapy*:* A therapy session typically lasts 50 minutes for indiviual sessions and 80 minutes for couples sessions. I encourage you to arrive five to ten minutes early, to mentally "switch gears" and take advantage of the entire session time.

Risks and Benefits: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will encourage you to respond openly and honestly.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. As your therapist, I may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating.

Agreement for Psychotherapy Services (Continued)

Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, sand tray, play therapy, expressive therapy, and/or psycho-educational techniques. I welcome any questions you may have about the therapy process and practices so please feel free to discuss these with me.

Cancellation Policy, Financial Terms, and Insurance Coverage

1. If you need to **cancel a session**, please know **I require at least 24 hours notice,** otherwise **there will be a charge for your missed session** (charged to you, not your insurance company). You can leave a message on my voice mail 24 hours a day, 7 days a week. I also recommend you do NOT text me to cancel your appointment. Due to the unreliable nature of todays technology, I may not get your text 24 hours prior to your appointment. After we discuss this (on or before our first session), I will note any different arrangements here: **Fees:** _____Per hour
3. If **you are late**, we will meet for the remainder of your scheduled session. If you are more than 15 minutes late and I have not heard from you, I will assume you are not coming and may leave the office.
4. **Telephone time** is limited to 10 minutes, beyond which, I will bill you at my standard rate at 15 minute intervals. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.
5. **Additional Charges:**
   Additional charges may be incurred for the following: written report at client request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office or special meetings. Time outside this office is usually charged door to door. Any additional charges will be discussed in advance and agreed upon. I charge for extensive telephone calls (see above). These charges are calculated on my regular hourly fee and in most cases are not covered by insurance. **Initial(s) Here: _____**

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you shall pay the actual balance due plus any collection expenses for 30-50% of any balance owing and any attorney's fees.

Agreement for Psychotherapy Services (Continued)

You are responsible for obtaining prior authorization for treatment from your insurance carrier. As a courtesy, I can provide you with a statement at the end of each month for you to submit to your insurance. You are ultimately responsible for payment for my psychotherapy services. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

Initial(s) Here: _____

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, the possible risks, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining these treatments, and will gladly do so.

Telephone and Emergency Procedures: If you need to contact me between sessions, please call me at **(805) 428-6655** and I will respond at my earliest convenience. If an emergency arises, please indicate it clearly in your message. If you have not heard from me after a few hours, please call again (there are occasions where your page does not reach me due to technical error). If you need to talk to someone right away, or if there is a life-threatening emergency, please call 911 or go to the nearest Emergency Room at a local hospital.

Confidentiality: An important aspect of our therapeutic relationship is confidentiality. Knowing that I will keep our communications private helps to make this a safe place for you to explore, to learn and to grow. Please be aware that the only exceptions to confidentiality are: 1) when you have given written consent for me to share information, 2) when I am required to do so by law, as in cases of suspected child, elder or dependent abuse, or actual or potentially dangerous behavior toward yourself or others, or 3) as required/allowed by HIPPA. Please read the HIPPA form for further clarification of the privacy of your health information and records.

Initial(s) Here: _____

Terminating Treatment:
Termination from therapy is an important process, which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage clients to participate with me in this process of finding out what was helpful, as well as what could have been more helpful. It is your right to terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. I do request that you do come in to discuss leaving and any feelings that may be associated with the process. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions (unless a special

Agreement for Psychotherapy Services (Continued)

arrangement has been made), or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

If there are specific phone numbers you WOULD like me to use to contact you, please note, and give me directions as to what I may and may not say, directly or in a message:

_____

If there is another address that you WOULD like statements sent to, please state here:

_____

If there are phone numbers and/or addresses on the intake form that you WOULD NOT like me to use, please state:

Initial(s) Here: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name _____ Phone_____ Relationship _____

Consent for Treatment

I authorize and request my therapist to carry out psychological evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

_____ _____
Client Signature **Date**

_____ _____
Client Signature **Date**

_____ _____
Therapist Signature **Date**

Client Questionnaire

Name_____ **Date**_____

Why are you here? Describe reasons for seeking help.

What help do you expect from therapy?

Is there anything from your past history that may be related to the difficulties you are having now? (trauma, abuse, substance use, learning difficulties etc....)

On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your current difficulties?

Are you depressed at this time? Yes____ No_____ Sometimes_____
How serious would you say your depression is? (Scale of 1-10) _____
Have you had any suicidal thoughts? Yes_____ No_____
Have you ever attempted suicide? Yes_____No_____
Any history of suicide attempts in family members? Yes_____ No_____
Who? _____
Whom have you presently consulted about your present problems?
_____
List your five worst fears: Worst fear first: 1)_____2)_____
3)_____ 4)_____ 5)_____
What do you consider your strengths?_____
_____

Please check all of the following which are, or have been, problems for you:

__ Anxiety	**__Loneliness**	**__Claustrophobia**	**__Marital problems**
__Shyness	**__Nightmares**	**__Bowel problems**	**__Lack of appetite**
__Tension	**__Overweight**	**__Can't have fun**	**__Can't keep a job**
__Tremors	**__Child abuse**	**__Hearing noises**	**__Stomach problems**
__Insomnia	**__Nail biting**	**__Money problems**	**__Can't concentrate**
__Dizziness	**__Underweight**	**__Suicidal ideas**	**__Lack of exercise**
__Headache	**__Can't decide**	**__Neglect**	**__Can't make friends**
__Parenting	**__Palpitations**	**__Fainting spells**	**__Don't like weekends**
__Tiredness	**__Feel panicky**	**__Unable to relax**	**__Bad home conditions**
__Alcohol use	**__Memory problems**	**__Inferiority feelings**	**__Angry**
__Drug use	**__Over-ambitious**	**__School problems**	**__Sexual problems**
__Depression	**__Seeing things**	**__Sexual assault**	**__Sexual abuse**
__Eating disorder	**__ADD (ADHD)**	**__Fearful**	**__Sleeping trouble**
__Physical abuse	**__Unemployment**	**__Family Violence**	

Client Questionnaire (Continued)

Name_____ **Date**_____

Other problems: _____

_____

Physical History- Check any that may apply, past or present:

__Heart problems	__Liver problems	__Shortness of breath
__Cancer	__Immune disease	__Hepatitis/jaundice
__Pain or pressure in chest	__Severe headaches	__Diabetes
__High blood pressure	__Head injury	__Tuberculosis
__Sexually transmitted disease	__Stroke	__Alcoholism
__Drug Abuse	__Epilepsy/convulsions	__Asthma
__Allergies	__Seizures	__Kidney problems
__Bed wetting/soiling	__PMS	__Hormone therapy
__Pregnancy #___	__Abortion #___	__Head Injury

Family of Origin History (parents, siblings, grandparents, aunts, uncles)
Please circle any that apply:

Depression	Bipolar (manic/depression)	Eating disorder	Alcoholism
Violence	Child abuse/sexual abuse	Jail	Drug abuse
Anxiety	Attention deficit disorder	Trauma	Schizophrenia
Gambling	Suicide	Pornography	School failure

Alcohol or other substance use: Please indicate past and current use.

Alcohol_____ **Amount**_____**Frequency**_____

Marijuana_____**Amount**_____**Frequency**_____

Cocaine_____ _____**Amount**_____**Frequency**_____

Methamphetamine ____**Amount**_____**Frequency**_____

Others_____