**Client Intake Information and Questionnaire**

**Sydney Isley, Marriage and Family Therapist**

**DBA Chino Valley Therapist**

Please fill in the information below and bring it with you to your first session. Please note, information provided on this form is protected by your right to confidentiality and the psychotherapist-patient privilege.

**Personal Information**

Name: *Click here to enter text.*

Date: *Click here to enter a date*

Parent/Legal Guardian (if under 18): *Click here to enter text.*

Address: *Click here to enter text.*

Home Phone: *Click here to enter text.*

 May we leave a message? [ ]  Yes [ ]  No

Cell/Work/Other Phone: *Click here to enter text.*

 May we leave a voicemail and/or text message? [ ]  Yes [ ]  No*.*

Email: *Click here to enter text.*

May we leave a message? [ ]  Yes [ ]  No

Emergency Contact: *Click here to enter text.*

Emergency Contact Phone Number: *Click here to enter text.*

**\**Please note: Email and texting correspondence is not considered to be a confidential medium of communication.***

DOB: *Click here to enter a date.*

Age: *Click here to enter text.* Gender: *Click here to enter text.*

Marital Status:

[ ]  Never Married [ ]  Domestic Partnership [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed

Referred By (if any): *Click here to enter text.*

**History**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? [ ]  No [ ]  Yes, previous therapist/practitioner: *Click here to enter text.*

Are you currently taking any prescription medication? [ ]  Yes [ ]  No

If yes, please list: *Click here to enter text.*

Have you ever been prescribed psychiatric medication? [ ]  Yes [ ]  No

Please list current medications: *Click here to enter text.*

**General and Mental Health Information**

1. How would you rate your current physical health?

 (Please select one) [ ]  Poor [ ]  Unsatisfactory [ ]  Satisfactory [ ]  Good [ ]  Very good

 Please list any specific health problems you are currently experiencing: *Click to enter text.*

1. How would you rate your current sleeping habits?

(Please select one) [ ]  Poor [ ]  Unsatisfactory [ ]  Satisfactory [ ]  Good [ ]  Very good

 Please list any specific sleep problems you are currently experiencing: *Click to enter text.*

1. How many times per week do you generally exercise? *Click here to enter text.*

 What types of exercise do you participate in? *Click here to enter text.*

1. Please list any difficulties you experience with your appetite or eating problems: *Click here to enter text.*
2. Are you currently experiencing overwhelming sadness, grief or depression? [ ]  No [ ]  Yes

 Have you ever been hospitalized for psychiatric care? [ ]  No [ ]  Yes

 Are you feeling suicidal? [ ]  No [ ]  Yes

 If so, please describe: *Click here to enter text.*

 Any Plans or Means? *Click here to enter text.*

1. Are you currently experiencing anxiety, panics attacks or have any phobias? [ ]  No [ ]  Yes

 If yes, when did you begin experiencing this? *Click here to enter text.*

1. Are you currently experiencing any chronic pain? [ ]  No [ ]  Yes

 If yes, please describe: *Click here to enter text.*

1. Do you drink alcohol more than once a week? [ ]  No [ ]  Yes
2. How often do you engage in recreational drug use?

 (Please select one) [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Infrequently [ ]  Never

1. Are you currently in a romantic relationship? [ ]  No [ ]  Yes

 If yes, for how long? *Click here to enter text.*

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? *Click here to enter text.*

1. What significant life changes or stressful events have you experienced recently? *Click here to enter text.*

**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 (e.g. father, grandmother, uncle, etc.)

Please select one and list family member.

Alcohol/Substance Abuse [ ]  No [ ]  Yes *Click here to enter text.*

Anxiety [ ]  No [ ]  Yes *Click here to enter text.*

Depression [ ]  No [ ]  Yes *Click here to enter text.*

Domestic Violence [ ]  No [ ]  Yes *Click here to enter text.*

Eating Disorders [ ]  No [ ]  Yes *Click here to enter text.*

Obesity [ ]  No [ ]  Yes *Click here to enter text.*

Obsessive Compulsive Behavior [ ]  No [ ]  Yes *Click here to enter text.*

Schizophrenia [ ]  No [ ]  Yes *Click here to enter text.*

Suicide Attempts [ ]  No [ ]  Yes *Click here to enter text.*

**Additional Information**

1. Are you currently employed? [ ]  No [ ]  Yes

 If yes, what is your current employment situation? *Click here to enter text.*

 Do you enjoy your work? Is there anything stressful about your current work? *Click to enter text.*

2. Do you consider yourself to be spiritual or religious? [ ]  No [ ]  Yes

 If yes, describe your faith or belief: *Click here to enter text.*

3. What do you consider to be some of your strengths? *Click here to enter text.*

4. What do you consider to be some of your weaknesses? *Click here to enter text*

5. What would you like to accomplish out of your time in therapy? *Click here to enter text.*

**Agreement for Service/Informed Consent for Minors**

**Sydney Isley, Licensed Marriage and Family Therapist**

 **DBA Chino Valley Therapist**

**Introduction**

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Sydney Isley, Licensed Marriage and Family Therapist for the minor child(ren) and is intended to provide (herein “Representative(s)”) with important information regarding the practices, policies and procedures of Sydney Isley, Licensed Marriage and Family Therapist, and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Minor Client Name *Insert Minor Client Name*

Parent or Legal Guardian *Insert Parent or Legal Guardian Name*

Parent or Legal Guardian *Insert Parent or Legal Guardian Name*

**Policy Regarding Consent for the Treatment of a Minor Child**

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

**Therapist Background and Qualifications**

Sydney Isley has been practicing as a licensed marriage and family therapist (LMFT) for 4 years, working mostly with adults, children, couples, adolescents and groups. Therapist’s theoretical orientation can be described as a generalist with emphasis in Cognitive Behavioral Therapy.

**Risks and Benefits of Therapy**

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well

as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

**Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice.

As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient’s family members or caregivers.

**Records and Record Keeping**

Therapist may take notes during session and will also produce other notes and records regarding Patient’s treatment. These notes constitute Therapist’s clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient or representative. Should Patient or Representative request a copy of Therapist’s records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient, or Representative, with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider.

Representative will generally have the right to access the records regarding Patient. However, this right is subject to certain exceptions set forth in California law, including, but not limited to, the right of Patient’s therapist to deny such access if such therapist believes such action is in the Patient’s best interests. Should Representative request access to Therapist’s records, such a request will be responded to in accordance with California law. Therapist will maintain Patient’s records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. However, after ten years, Patient’s records will be destroyed in a manner that preserves Patient’s confidentiality.

**Confidentiality**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, if Patient is twelve years of age or older. Patient information may also be disclosed as required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards another person, or when a patient is dangerous to him/herself or the person or property of another.

Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient’s progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Patient, including suicidality.

**Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient’s, or Representative’s, legal matter. Therapist will generally not provide records or testimony unless compelled to do so.

Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist’s usual and customary hourly rate of $140.00.

In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient’s parents.

**Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient’s behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient’s behalf.

When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, the minor’s counsel, or one of the Parents. In some cases, Parents do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney. Patient, or Representative, should be aware that

he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

**Fee and Fee Arrangements**

The usual and customary fee for service is $140.00 per 45-50-minute session. Sessions longer than 45-50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, HMOs, managed care organizations, or other third-party payers, or by agreement with Therapist. The agreed upon fee between Therapist and Representative is $140.00 or other agreed upon fee $*Enter rate here*.

Therapist reserves the right to periodically adjust fee. Representative will be notified of any fee adjustment in advance. From time-to-time, Therapist may engage in telephone contact with Patient or Representative for purposes other than scheduling sessions. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient or Representative and with the advance written authorization of Patient or Representative. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Representative is expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards.

**Insurance**

Representative is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Representative is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Therapist is a contracted provider with the following companies: Sydney Isley Marriage and Family Therapy, Inc, DBA Chino Valley Therapist.

If Representative intends to use benefits of his/her health insurance policy, Representative agrees to inform Therapist in advance. OR Therapist is not a contracted provider with any insurance company, managed care organization. Should Representative choose to use his/her insurance, Therapist will provide Representative with a statement, which Representative can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

**Cancellation Policy**

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist’s voice mail at 909-907-4236.

**Therapist Availability**

Therapist’s office is equipped with a confidential voice mail system that allows Patient or Representative to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the

next business day) but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient or Representative should call 911, or go to the nearest emergency room.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist’s scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party’s decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

**Acknowledgement**

By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist and has had any questions regarding its terms and conditions answered to Representative’s satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Patient Name: *Insert Minor Client Name*

Signature of Patient: *Type Signature* Date: *Click to enter a date.*

(if Patient is 12 or older)

*Type Signature* *Type Relationship* Date: *Click to enter a date.*

Signature of Representative (and relationship to Patient)

*Type Signature* *Type Relationship* Date: *Click to enter a date.*

Signature of Representative (and relationship to Patient)

**Consent for Treatment and Limits of Liability**

**Sydney Isley, Licensed Marriage and Family Therapist**

 **DBA Chino Valley Therapist**

**Limits of Services and Assumption of Risks**:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

**Limits of Confidentiality**:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

**Duty to Warn and Protect**

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to harm another person, the therapist is

required to warn the possible victim and notify legal authorities, if the victim is reasonably identifiable. However, if you disclose a plan to harm another person, the therapist is required to notify legal authorities f the victim is foreseeable.

**Abuse of Children and Vulnerable Adults**

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e., the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers**

Insurance companies and other third-party payers are given information that they request regarding services to the clients. The type of information that may be requested includes types of service,

dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

*By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.*

Client Signature: *Type Signature* Date: *Click to enter a date*

Parent/Guardian Signature: *Type Signature* ­­­­ Date: *Click to enter a date*

(if Client under 18)

**Chino Valley Therapist Cancellation Policy**

**Sydney Isley, Licensed Marriage and Family Therapist**

 **DBA Chino Valley Therapist**

If you are unable to attend an appointment, I request that you provide at least 24 hours advanced notice to our office. Since I am unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. In that case, if I am able to place you in another spot in that same calendar week, no cancellation fee will be assessed. For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be charged in full on your next visit to my office. I appreciate your help in keeping the office schedule running timely and efficiently.

Client Signature: *Type Signature*

Parent/Guardian Signature: ­­­­*Type Signature* Date: *Click to enter a date*

(if Client under 18)

**Client Email/Texting Informed Consent Form**

**Sydney Isley, Licensed Marriage and Family Therapist**

 **DBA Chino Valley Therapist**

**Risk of using email/texting**

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

* 1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
	2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
	3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
	4. Employers and on-line services have a right to inspect emails sent through their company systems.
	5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
	6. Email and texts can be used as evidence in court.
	7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

**Conditions for the use of email and texts**

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist’s intentional misconduct. Clients/Parent’s/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All email will usually be printed and filed into the client’s medical record. Texts may be printed and filed as well.
4. Provider will not forward client’s/parent’s/legal guardian’s identifiable emails and/or texts without the client’s/parent’s/legal guardian’s written consent, except as authorized by law.
5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
7. It is the client’s/parent’s/legal guardian’s responsibility to follow up and/or schedule an appointment if warranted.

**Client Acknowledgement and Agreement**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name: *Insert Name*

Client signature: *Type Signature* Date: *Click to enter a date*

Parent/Legal Guardian name: *Insert Name*

Parent/Legal Guardian signature: *Type Signature* Date: *Click to enter a date*

Provider name: *Insert Name*

Provider signature: *Type Signature* Date: *Click to enter a date*