Dr. Shannon J. Curry, PsyD, MSCP
Dr. Carey Incledon, PsyD

Curry Psychology Group
200 Newport Center Drive
Suite 204
Newport Beach, CA 92660

T. 949.258.9777
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Informed Consent for Gottman Method Couples Therapy

Welcome: Before starting your therapy, it is important to know what to expect and to understand your rights and commitments. We have created this form to be as transparent as possible about the nature of the couples therapy process, so you are fully informed prior to starting the therapy.

Our credentials: Dr. Shannon Curry is a Clinical Psychologist who is licensed in the state of California by the Board of Psychology. Dr. Carey Incledon is a Doctor of Psychology who is completing her residency training under the license and supervision of Dr. Curry. Dr. Incledon is a registered Psychological Assistant with the California Board of Psychology. Drs. Curry and Incledon have completed all three levels of advanced training in the Gottman Method of couples therapy.

What to expect: Couples who enter into Gottman Method Couples Therapy begin with an assessment process that then informs the therapeutic framework and intervention:

1. *Assessment*: A conjoint session, followed by individual interviews with each partner are conducted. Couples complete online questionnaires and then receive detailed feedback on their relationship.
2. *Therapeutic Framework*: The couple and therapist decide on the frequency and duration of the sessions.
3. *Therapeutic Interventions*: Interventions are designed to help couples strengthen their relationships in three primary areas: friendship, conflict management, and creation of shared meaning.

Interventions designed to increase closeness and intimacy are used to improve friendship, deepen emotional connection, and create changes which enhances the couples shared goals. Couples learn to replace negative conflict patterns with positive interactions and to repair past hurts. Relapse prevention is also addressed.

Limitations to couples therapy: Gottman Method Couples Therapy has been shown to have benefits for couples. It often leads to a significant reduction of feelings of distress, resolution of specific problems, and a stronger relationship. In many cases, it has moved couples from thinking of ending their relationship to recommitting to it in new ways. However, it is important that you also understand the risks involved. Despite the "nuts and bolts" approach of this method, you will be asked to address areas of difficulty in your relationship. As a result, you and/or your partner may experience uncomfortable feelings like sadness, guilt, anxiety, anger, loneliness, and helplessness. Your therapy may also involve recalling unpleasant aspects of your history together and/or individually. Difficulties between the two of you may become temporarily amplified. Additionally, difficulties with people important to you may also occur, family secrets may be disclosed, and despite our best efforts, therapy may not work out well. Couples' therapy will only be effective in cases where both partners put in a good faith effort to work on their problems and their relationship. Deliberate dishonesty or deceit, unwillingness to introspect and take responsibility for one's actions, or lack of interest and motivation to engage in the couples' therapy process by one or both partners will undermine the therapy. Thus, we can make no guarantees about how the therapy process will be for the two of you specifically or what the outcome will be for your relationship. In addition, couples' therapy is not advisable in the following situations:

- If there is active alcohol and/or drug addiction on the part of either or both partners, from either partner's perspective
- If there is serious violence in your relationship, threats by one or both partners that serious violence might occur, or fear of such serious violence on the part of one or both partners
- If either partner currently has an untreated major mental illness (schizophrenia, recurrent psychotic depression, or bipolar/manic-depressive illness.) This does not include past,

successfully treated psychotic episodes (e.g. post-partum depression with psychosis).

- If there is an undisclosed, current affair that you are not willing to disclose (such secrets predict marital therapy failure)
- If either partner is currently experiencing suicidal or homicidal thoughts, or has a history of serious harm inflicted on him/herself or another person

24-hour cancellation policy: Couples therapy is billed according to the fees outlined on the attached payment policy page. If you are prevented from attending your scheduled session and do not cancel your appointment at least 24 *business hours* hours in advance, you understand that you will be charged the full session fee. This practice of being charged for no-shows or late cancellations is standard practice in the field, and takes into account that you are not just paying for services rendered, but reserving a time slot which your therapist will not be able to offer to someone else on short notice.

Confidentiality: When you attend sessions with a psychologist, the information you share is protected by strict confidentiality laws enforced both by the California Board of Psychology and California state law. Without your written consent and permission, we cannot reveal whether or not you are a client of the Curry Psychology Group, nor can we discuss any information from our sessions with a third party.

The following are exceptions to this rule:

- If one of you pose an imminent danger to yourself, your partner, or a third person, we are allowed to disclose information to law enforcement personnel or hospital staff to keep you safe and coordinate your care.
- If you talk about events that lead us to believe that a child under the age of 18 or an elderly or disabled person is at risk of emotional, physical or sexual abuse; neglect; or exploitation; we are required by law to make a report to California Child or Adult Protective Services.
- If a Judge orders us to release information or if we are required to respond to a lawfully issued subpoena.

The couple is the client: When you attend couples therapy sessions, the couple is considered "the client," and your mental health records therefore belong to both of you. This means that except in the circumstances outlined above, we will require a written consent from both of you to disclose any information from your record to a third party.

Litigation limitation: The ethics and rules of our profession preclude us from serving in a dual-role of therapist and evaluator, meaning that our role as your therapist prevents us from providing a formal evaluation that would render an opinion for legal or disability purposes. Furthermore, due to the private nature of the therapeutic process, it is agreed that this process should be protected and should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on our clinicians to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If we are ordered to provide testimony on your behalf, you agree to pay a fee of $300 per hour to include all time spent on correspondence, record review, document preparation, travel to and from Court, and wait time at court.

Between-Session Contact: Please contact the office at 949-258-9777 with administrative or scheduling questions. On weekdays, we will typically return administrative calls within 24 hours. We do not discuss clinical matters by phone or without an appointment. In the event of a clinical emergency, such as acute thoughts of harming oneself or others or experiencing a traumatic life event, you may leave a message on your provider's confidential voicemail indicating the nature

of the emergency, and your provider will return your call as soon as possible. If you feel you are in imminent danger to yourself or others or if you feel that your health is at risk, please visit your nearest emergency room; dial 9-1-1; or call the National Crisis Lifeline day or night for free immediate support at 1-800-273-8255.

E-mail and/or text message appointment notifications: When appointments are scheduled, automatic email and text reminders of your appointment will be sent to the e-mail and phone number you used when scheduling your first appointment. *By signing this consent form, you agree to receive these notifications, and understand that email and text is not a confidential medium for transmitting health information.*

Termination by the therapist: We reserve the right to terminate treatment under certain conditions which compromise our ability to provide effective services, the client's ability to benefit from services, or when it is legally and/or ethically appropriate to do so. Such circumstances include, but are not limited to:

- Three missed appointments or late-cancellations within a six-month period
- Non-adherence to the treatment plan
- Non-compliance with practice policies & procedures
- Refusal to accept recommendations for a higher level of or supplemental care
- Behaviors that are disrespectful, devaluing, threatening, or otherwise inappropriate toward the provider, staff, other clients, or any persons present in the building
- Misrepresentation or omission of pertinent clinical information
- Non-payment of fees

No secrets: As couples therapists who are entrusted with information from both partners in a relationship, we have a policy of "No Secrets", which means that we cannot promise to protect secrets of either partner from the other person, especially if the secret is harmful or destructive to the process of the therapy itself or undermines the agreed upon intention of the therapy.

We, the client, understand and consent to the above terms, and agree to initiate treatment.

______________________________ ________________
Client Signature Date

____
Client Name

______________________________ ________________
Client Signature Date

____
Client Name

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Permission for Digitally Recording Couples Therapy Sessions

Video feedback is utilized as a primary tool in Gottman Method Couples therapy. This means that therapy sessions will be video recorded and certain exercises and dialogues will be reviewed from time-to-time. By reviewing the recordings in session, we can "stop action" and process how each partner might approach a discussion in a more productive way. Viewing the recordings also enables you to witness your progress as your relationship becomes more satisfying.

In addition to in-session use, your therapist may use brief segments of video recordings to receive consultation from Drs. John or Julie Gottman; Dr. Nancy Young, a certified master-trainer in the Gottman method, and/or another assigned Gottman master-trainer consultant. Case consultation is an important feature of Gottman therapy that assures quality care and continuing education among Gottman therapists. If a segment of a video recording in which you are featured is reviewed, your name will remain confidential at all times. Furthermore, all matters discussed in consultation will remain completely confidential within the aforementioned Gottman Institute Staff. Video recordings are not a part of your clinical record and will be erased when they are no longer needed for in-session feedback or consultative purposes.

Video recordings are the property of Curry Psychology Group and will remain in our possession or stored in locked facilities at all times. Copies may be sent to the Gottman Institute for the purposes noted above. Should you wish to review the recordings for any reason, we will arrange a session to do so.

Clients' Agreement

I understand and accept the conditions of this statement and give my permission to have my therapy sessions videotaped or digitally recorded. I understand I may revoke this permission in writing at any time but until I do so it shall remain in full force and effect until the purposes stated above are completed.

______________________________ ____________
Client Signature Date

______________________________ ____________
Client Signature Date

Agreement to Pay for Psychological Services

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Cancellation Policy: Please contact the office at 949-258-9777 to cancel any upcoming appointment. Cancellation of an appointment must be made by noon on the business day prior to the appointment. Since alternative bookings are unlikely after that time, our policy includes a charge of the full session fee for "no show" or late cancellations occurring with insufficient notice. This represents the amount of time reserved for your service. Note that this fee is not eligible for payment or reimbursement by insurance.

If cancelling an appointment that is scheduled on a Monday, notice must be received by our office on the Friday prior to the appointment. Cancellations received during the weekend will be considered late and the fee will apply. Similarly, if an appointment is scheduled the day after a holiday, notice of intent to cancel must be received by the last business day prior to the holiday.

Payment Policy: You or your payer will be charged at the time of each appointment according to the fees outlined in the attached fee schedule. We are in-network with Tricare West military insurance. We also bill out-of-network insurance plans with a deposit for the full service fee. Credit card information will be obtained at your first appointment with the Curry Psychology Group and automatic payments can be arranged for future sessions. Acceptable payment methods include credit card and cash.

To check your out-of-network insurance benefits, we recommend that clients contact their insurer at the number listed on the back of their insurance card to ask the following questions:

1. Does my plan include out-of-network benefits for mental health/behavioral healthcare?
2. What is the maximum allowed amount if I receive individual psychotherapy, service code 90837, at an office, with a psychologist?
3. What percentage of the allowed amount does my plan pay?
4. Do I have an insurance deductible that I would have to pay before my out-of-network benefits are provided?

Tricare West/Military Beneficiaries: Clients with Tricare West will be charged the appropriate copayment or deductible fee (as shown to our office from Tricare West's eligibility database) at the time of each appointment. If, after charging for the copayment or deductible fee, the office comes to know through your insurance's Explanation of Benefits that the client's amount due is greater or less than the amount originally charged to the client, the office will bill the client for the balance or refund the excess to your patient account as applicable. The client accepts financial responsibility for all eligible services that are not paid by their insurance plan within 30 days of the date of service.

GOTTMAN METHOD COUPLES THERAPY FEE SCHEDULE

SERVICES OFFERED	DR. SHANNON CURRY	DR. CAREY INCLEDON
Assessment Phase		
INITIAL APPOINTMENT – 90 MIN + ONLINE ASSESSMENT - Includes your links to the Gottman Institute Relationship Checkup online assessments & your therapist's scoring and interpretation of assessment results	385..	285.
INDIVIDUAL ASSESSMENT SESSION – 55 MIN	250.	175.
ASSESSMENT FEEDBACK SESSION – 75 MIN	300.	225.
Intervention Phase		
COUPLES THERAPY/INTERVENTION SESSION – 75 MIN	300.	225.
COUPLES THERAPY/INTERVENTION SESSION – 90 MIN	375.	275.
Supplemental Services		
BETWEEN-SESSION PHONE CONTACT Per 15 min	75.	60.
LETTERS AND FORM COMPLETION Per 30 min	150.	100.

By signing below the Client indicates their understanding and agreement to the Curry Psychology Group's payment policies and fees as outlined in this document.

Signature of Client **Date**

Printed Name

Signature of Client **Date**

Printed Name

CURRY PSYCHOLOGY GROUP
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Electronic Payment Authorization

Please enter the card information you wish to keep on file for automatic deduction of your session fee, copayment, or insurance deductible (if applicable). Only fees which have been previously disclosed and agreed to by you per the "Agreement to Pay for Psychological Services" will be charged.

The following credit and debit cards are accepted: Visa, MasterCard, Discover and AMEX.

Client Name: ___________________________________

Cardholder Information (*Please indicate the name and address associated with the credit or debit card you wish to use*):

Cardholder Name: ___________________________________

Address: _________________________________ City___________________ State: ______ Zip: ________

Main Phone Number: __________________ Email: ____

Credit/Debit Card Information:

Card Type (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Card Number: ____

Expiration Date: ____________ Security Code (3-digit code on back of card): __________

I, the cardholder, authorize fees for services rendered by this practice to be deducted from the credit or debit card listed above.

___________________________________ __________________

Cardholder Signature Date

CURRY
PSYCHOLOGY GROUP

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NEWPORT BEACH | CA 92660
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CONTACTUS@CURRYGROUP.ORG

NEW CLIENT INFORMATION FORM

Couples: Each partner should complete their own information form prior to the first session. Please allow approximately 30 – 45 minutes to complete the form. We realize that we request quite a bit of information from clients at the start of therapy. Please bear with us, as this step will help us understand multiple influences in your life so that we can be as effective as possible in understanding your current situation and helping you reach your goals.

Today's Date: ____________________

I. DEMOGRAPHIC INFORMATION

Client Information

Client name: ______________________________ Date of birth: ____________ Age: __________

Home address: ____ Apt.: __________

City: ____ State: ______ Zip: ___________

Employer: ____________________________________ City of Employment: _______________

Job Title: ____

Cell Phone: ________________________ Home Phone: ______________________________

Work Phone: _______________________ e-mail: ___________________________________

Calls or e-mail will be discreet, but please indicate any restrictions: ______________________________

May we send a text message or email appointment reminder the day before your appointment? ☐Yes ☐No

Insurance Information

Insurance company: ____

Insurance ID # (*For Tricare, enter sponsor's social security #*): ________________________________

Patient's relationship to the sponsor/primary insured: ☐ Self ☐ *Spouse** ☐ *Child/Dependent**

Sponsor name: ___________________________________ Date of birth: __________________

Sponsor insurance ID# (*For Tricare, enter sponsor's Social Security #*): ____________________________

Sponsor job title & employer (*Military, enter branch, MOS & rank*): ______________________________

Emergency Contact

Name: _______________________ Relationship: ______________ Phone: ____________________

Address: ____

How did you learn about us?

❑ Online Search ❑ Psychology Today ❑ Insurance Directory ❑ Referred by: ____________________________

If referred, may we have your permission to thank this person for the referral? ❑ Yes ❑ No

If referred, how did this person explain how we might be of help to you?

____

____

II. PERSONAL IDENTITY

Race/Ethnicity

Ethnicity/national origin: _________________________________ Race: ___________________________________

Other related way you identify yourself: ____

Religion/Spirituality

Current religious denomination/affiliation: ____

Religious/Spiritual Involvement: ❑ None ❑ Some/Irregular ❑ Active

How important are spiritual concerns in your life? ____

Which (if any) church, synagogue, temple, or meeting are you involved with? _________________________________

Gender Identity

☐ Bigender (*having two genders*)

☐ Female

☐ Gender fluid (*identification is fluid/shifting between two or more genders*)

☐ Male

☐ Non-Binary (*unbounded gender*)

☐ Omnigender (*possessing all genders*)

☐ Other: ______________________

☐ Transgender female (*non-identification with male sex assigned at birth*)

☐ Transgender male (*non-identification with female sex assigned at birth*)

Sexual Orientation

☐ Asexual (*lack of sexual or romantic interest in members of any gender or sex*)

☐ Bi-Sexual (*sexual or romantic interest in both men and women*)

☐ Gay (*sexual or romantic interest in members of the same gender or sex*)

☐ Heterosexual (*sexual or romantic interest in a member of the opposite sex or gender*)

☐ Lesbian (*sexual or romantic interest in women by women*)

☐Other:____________________

☐ Pansexual/Omnisexual (*sexual or romantic interest for people of all genders & sexes*)

☐ Questioning (*still exploring or unsure of sexual orientati*

III. Social History

Relationship Status (please check *all* that currently apply):

❑ Breaking Up
❑ Dating
❑ Divorced
❑ Committed Relationship
❑ Domestic Partnership
❑ Living Apart
❑ Living Together
❑ Married
❑ More than One Relationship
❑ Open Relationship
❑ Other: ____________________
❑ Polyamorous Relationship
❑ Separated
❑ Single

Name(s) of current spouse/partner(s): ____

If divorced or separated, name of ex-partner(s):____

Are you satisfied with the current quality of your relationship or love life? ❑ Yes ❑ No

If you answered *no*, please describe why: ____

____

Residential History: Please list all the places you have lived in the *last 5 years*.

Year - Year	City, State	Reason for moving	Any issues transitioning?

Household Information: Please list all people living in your household (use back for additional people).

Name	Relationship to Patient	Age	Profession

Family Tree:

Please list any immediate family members *who are not in your household* (parents, siblings, children, spouse). Include non-relatives or extended family members who have played a particularly important role in your life (e.g., a grandparent, aunt/uncle, or family friend who was responsible for your care).

Name	Relationship to Patient	Age *(if living)*	Profession	City, State

Childhood:

Where were you born and raised? ____

Were your parents together when you were born? ❑ Yes ❑ No

If *yes*, are they still together? ❑ Yes ❑ No: *How old were you when they split?* __________

Who was your primary caregiver growing up (*may be more than one*)? ______________________

How was love and/or affection shown in your household? ______________________________

____

Education:

Highest level of education completed/degree(s) received: ______________________________

Have you ever received special education services, academic accommodations (e.g., prolonged test time), a 504 plan or IEP? ❑ No ❑ Yes - *grades & services received:* ______________________

____

Please list *high schools*, *colleges* or *universities* attended:

Grade levels	School	Area of study	Degree or N/A	Reason for leaving (if did not graduate)

Legal

Please list any prior arrests, restraining orders, or legal charges:

Year	List Reason for Arrest/Restraining Order/Current Charges	Legal Outcome

IV. MEDICAL HISTORY

***Major Medical History*:** Please list any major medical conditions, serious illness or accidents, hospitalizations, medically necessary surgeries, or neurological events including loss-of-consciousness, seizures or convulsions.

Age	Illness/Diagnosis	Treatment(s) Received/ Medications Prescribed	Provider/Hospital	Outcome

Current Medical Provider: *From whom do you currently receive medical care?*

Physician Name: ___________________________________

City: ________________________________ **Phone:** _______________________________

Health Habits

1. **What kinds of physical exercise do you get?** ____

2. **How much coffee, cola, tea, caffeine do you consume each day?** ______________________________

3. **Do you try to restrict your eating in any way?** YES NO (Circle one)

If *yes*, describe *how*: ______________________________

If *yes*, describe *why*: ______________________________

4. **Do you have any problems getting enough sleep?** YES NO (Circle one)

Average hours of sleep per night: ________

If *yes,* what problems (falling asleep, staying asleep)? ______________________________

6. **Are you satisfied with the frequency of sex in your life?** YES NO (Circle one)

If *no*, what frequency would you prefer? ______________________________

7. **Are you satisfied with the quality of your sex life?** YES NO (Circle one)

If *no*, how would you like the quality to improve? ______________________________

8. **Do you drink alcohol?** YES NO (Circle one)

If *yes*, how many drinks do you have each day? ______________________________

9. **Do you use recreational drugs?** YES NO (Circle one)

If *yes*, what drugs and how much/how often? ______________________________

____

10. **Are there any medical or physical problems you are concerned about?** ______________________________

____

Women Only

Menstruation

1. If you currently menstruate, do you experience pain with your period? If so, how severe is the pain?

____

2. Do you experience mood changes with your period? If so, please describe:

____

Menopause

1. If your menopause has started, at what age did it start? ______________

2. What signs or symptoms have you had? ______________________________

Please list all pregnancies:

Age	Outcome of Pregnancy (e.g., Abortion, Delivery, Miscarriage, Stillbirth)	If you delivered, please describe any problems with delivery:

V. Mental Health History

Prior Mental Health Treatment

Please list any prior mental health treatment you received and any diagnosis. Include visits to a therapist, counselor, psychiatrist, psychologist, social worker, or mental health clinic, as well as any psychiatric hospitalizations, substance abuse treatment, or other residential treatment facilities.

Age	Issue/Diagnosis	Treatment(s) Received/ Was it helpful?	Provider or Hospital	Reason for termination

Are you currently seeing another mental health care provider (psychologist, psychiatrist, marriage & family therapist, counselor, or social worker)? ❑ **No** ❑ **Yes** *(If yes, please complete below)*

Provider's name & title: ______________________________

Phone: ______________ **City of Office Location** ______________

How long have you been under this provider's care? ______________

Reason for care: ______________________________

Do you plan to continue care with the above provider? ______________

Psychotropic Medications & Vitamins/Supplements

Please list any prescribed medications or herbal supplements that you have taken in the last 10 years to treat *mental health symptoms*.

Medication	Approximate dates (or age)	Purpose	Prescribed/supervised by

Family Mental Health History

Please list any members of your immediate or extended family who have been either formally diagnosed or suspected to have a mental illness, *including* substance and alcohol use disorders (e.g., depression, anxiety, alcoholism, addiction).

Name & Relationship to Patient	Illness/Issue	Diagnosed (Yes/No)	Please indicate any treatment history or other notes about what you know of their illness

History of Abuse

Were you ever abused as a child? ❑ Yes ❑ Unsure ❑ No

If you answered *yes* or *unsure*, please indicate any instances below that apply:

- ❑ Emotional abuse (underline any that apply) - *Willfully causing mental suffering of a child or endangering a child's emotional well-being through: Belittling; ridiculing; humiliating; name-calling; excessive screaming, cursing, raging at child; demeaning jokes; excessive teasing about capabilities or physical appearance; refusing love, attention or touch; shunning child from family; unpredictable, unreasonable & extreme reactions; locking child out of the home to discipline or punish; threats or intimidating behaviors; unreasonable demands placed on child; excessive or unreasonable punishment for typical childhood behaviors; isolating a child from peers or prohibiting normal play/opportunities for stimulation; promoting or rewarding unhealthy or criminal behaviors; exposing child to violence in the home; exposing child to other inappropriate or traumatic events)*

- ❑ Neglect – *Failure of caregiver to provide adequate food, clothing, shelter, or supervision (may or may not result in any physical harm to child)*

- ❑ Physical abuse – *Bodily injury inflicted on a child by willful cruelty, unjustifiable punishment, or corporal punishment*

- ❑ Sexual abuse – *Victimization of a child by sexual activities including molestation, indecent exposure, fondling, rape, incest, and exposure of a child to sexually inappropriate content (verbally or visually).*

Crisis & Coping

Briefly list any major crises that have occurred in your life *in the last 5 years*, and how you handled them:

____

____

____

____

During extremely difficult times in life, it is not uncommon for people to have thoughts about suicide. Please describe any times in your life when you experienced *thoughts* about ending your life (e.g., imagined it might be a relief from the pain you were suffering or thought it might be "the only way out" of your difficulties, etc.).

____

____

____

____

If you had such *thoughts*, but never attempted suicide, what prevented you from doing so?

____

____

____

If you have ever had a *plan* to commit suicide, please describe (1) when, (2) what stressors were occurring in your life, (3) whether you had the means available to you to carry out your plan (e.g., access to a lethal dose of medication or a weapon in the house, and (4) what prevented you from carrying out the plan:

____

____

____

____

If you have ever *attempted* suicide, please describe (1) when, (2) what stressors were occurring in your life, (3) the method used, and (4) how the attempt was intervened:

____

____

____

____

Please indicate whether you have experienced *thoughts* of suicide *within the last month:* ❑ No ❑ Yes

If *yes*, do you have a plan for how you would carry it out?

❑ No ❑ Yes (describe): ____

If *yes*, do you have the means to carry it out (e.g., access to a weapon, pills, etc.)?

❑ No ❑ Yes (describe): ____

Has a family member attempted or committed suicide (parent, aunt/uncle, grandparent, sibling, child)?

❑ No ❑ Yes (please describe): ____

Have you ever engaged in any self-harming behavior (e.g., cutting)?

❑ No ❑ Yes (please describe): ____

VI. STRENGTHS & RESOURCES

What are your major strengths? ____

____

____

When are you happy, relaxed, or enjoying yourself? ________________________________

____

____

What people and activities support or comfort you when you are struggling? ________________________

____

VII. Goals for Therapy

In your own words, please describe what brings you here today: ________________________________

____

____

____

When did this issue begin? ____

Please check any additional items below that are a concern for you.

- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Acculturation issues (adjusting to different culture)
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (believing things that aren't real)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Discrimination
- ❑ Disorganization
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Gambling
- ❑ Gender identity
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Hearing voices
- ❑ Housework/chores—problems, schedules, sharing duties
- ❑ Identity issues
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk-taking
- ❑ Legal matters, charges, suits
- ❑ LGBTQIA issues
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems

- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Paranoia
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Racism
- ❑ Relationship problems (friends, relatives, or work)
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual identity
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other
- ❑ Shyness
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stalking
- ❑ Stress, relaxation, stress management, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats
- ❑ Trauma
- ❑ Violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, overworking, can't keep a job, dissatisfaction, ambition

❑ Other concerns or issues: ____

Please look back over the concerns you have checked off. Which one do you *most* want help with?

____

What changes are you hoping therapy might lead to? ______________________________________

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Thank you for taking the time to answer these questions. We look forward to helping you reach your goals!