



## 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. Curry has completed all three levels of advanced training in the Gottman Method of couples' therapy.

Dr. Shannon J. Curry, PsyD MSCp

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

T. 949.258.9777  
F. 949.258.9749

**What to expect:** *Gottman Method Couples' Therapy* consists of two phases:

1. **Assessment:** This process includes an interview with the couple, followed by individual interviews with each partner. Couples also complete online questionnaires which provide comprehensive data on the relationship's strengths and challenges. Feedback on the results of the assessment is provided, and the recommended areas for intervention are discussed. This phase yields a scientifically-based, personalized treatment plan from which interventions are selected.
2. **Therapeutic Intervention:** In this phase, structured interventions that are designed to strengthen friendship, intimacy, and conflict management are introduced and practiced in each session. Couples learn to replace negative conflict patterns with positive interactions and to repair past hurts, and begin to create shared meaning and purpose in their relationship. Therapy ends once couples have reduced the behaviors that predict a split and are able to effectively use conflict management tools without the therapist. However, during the first year or two after therapy ends, follow-up sessions are recommended at six-month intervals to reinforce the skills learned in therapy and prevent relapse into negative conflict patterns.

**Gottman Method Intensive & Marathon Therapy Packages:** *Intensive* and "*Marathon*" *Therapy Packages* are available for couples who need to get help immediately, whose schedules do not allow for weekly therapy sessions, or who do not live in the vicinity of a therapist trained in the Gottman method. "*Marathon*" therapy is an intensive approach that helps couples move more quickly through their issues. Like the typical Gottman Method of Couples' Therapy, our marathon therapy packages all begin with an assessment before progressing into therapeutic interventions. For full-day packages, the first session is scheduled to begin at 10:00 a.m., and lasts 2 ½ hours, followed by an hour break for lunch. The afternoon session begins after lunch and continues for 2 ½ hours, for a total of 5 hours of intensive therapy. Intermittent breaks are provided throughout each session, and couples will receive a take-home package of tools and supplemental materials. The following intensive options are offered:

1. **Half-Day Assessment Package (3 ½ hours).** This half-day intensive is ideal for couples who want to get a quick start to the weekly therapy process by completing the assessment portion all at once. The assessment package includes the following:
  - Access to online Relationship Checkup Questionnaires
  - Interview with the couple - 90 min
  - Interview with each partner individually- 55 min each
  - Intervention plan prepared by Dr. Curry (plan will be shared in subsequent sessions as scheduled with the couple)
2. **One-Day Intensive Therapy Package (5 hours + breaks).** This full-day intensive package is intended for couples who have already completed the assessment process and who want to work through issues in therapy as quickly as possible. The package includes:
  - 5 hours of intensive therapy
  - A take-home package of tools and supplemental materials
3. **Two-Day Assessment & Intensive Therapy Package (10 hours + breaks).** Intended for

couples who want to complete the assessment quickly and make rapid progress through their issues. This package includes:

- All items in the Half-Day Assessment Package
  - Plus 6 ½ hours of intensive therapy
  - A take-home package of tools and supplemental materials
4. *Premarital Intensive Package (5 hours + lunch break)*. This full-day intensive is intended for couples who are hoping to strengthen their bond prior to marriage. It includes 5 hours of skill-building and relationship strengthening exercises to help couples increase intimacy and closeness before the wedding and preparing them to successfully manage future challenges. The premarital package includes a take home package of tools and supplemental material.

**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

**Cancellation policies:** Your appointment time is reserved especially for you. The practice of charging for no-shows or late cancellations (or retaining the deposit in the case of intensive package appointments) 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. If you are prevented from attending your scheduled session, you understand that you will be charged the full cost of the appointment or that your retainer will be forfeited if notice of the cancellation is not received by our office within the following time frames:

- *Gottman couples' therapy appointments*- At least 48 \*business hours\* (2 business days) prior
- *Half day intensive package appointments*- at least one calendar week (7 days) prior

- *One & two-day intensive packages*- at least two calendar weeks (14 days) prior

**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



## 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



Dr. Shannon J. Curry, PsyD MSCp

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

T. 949.258.9777  
F. 949.258.9749

## Agreement to Pay for Psychological Services

**Cancellation Policy for Couples' Therapy Appointments:** Please contact the office at 949-258-9777 to cancel any upcoming appointment. Cancellation of a couples' therapy appointment must be made by noon at least two (2) business days 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.

**Cancellation Policy for Marathon/Intensive Therapy Packages:** For clients who have booked a marathon/intensive therapy package, notice of a cancellation must be received two calendar weeks (14 days) prior to a one- or two-day intensive package session or the deposit will be forfeited. For half-day intensives, notice of a cancellation must be received one week (7 days) prior or the deposit will be forfeited.

**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. For intensive packages, a deposit will be collected at the time the appointment is scheduled. The deposit will be applied toward the appointment fee when the appointment has been attended. 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

<b>ASSESSMENT PHASE</b>	
<b>INITIAL INTERVIEW WITH COUPLE – 90 MIN</b> - Includes online access to the Relationship Checkup Questionnaires	385.
<b>INTERVIEW WITH EACH INDIVIDUAL PARTNER – 55 MIN EACH</b>	250.
<b>ASSESSMENT FEEDBACK/INITIAL COUPLES' THERAPY INTERVENTION – 90 MIN</b>	385.
<b>THERAPY/INTERVENTION PHASE (<i>Clients choose the duration</i>)</b>	
<b>COUPLES' THERAPY/INTERVENTION SESSION – 75 MIN</b>	325.
<b>COUPLES' THERAPY/INTERVENTION SESSION – 90 MIN</b>	385.
<b>COUPLES' THERAPY/INTERVENTION SESSION – 120 MIN</b>	565.
<b>“MARATHON” COUPLES' THERAPY PACKAGES</b> <i>NOTE: All intensive packages require a deposit at the time of booking.</i>	
<b>ASSESSMENT PACKAGE - 3 ½ HOURS</b> <i>Ideal for couples who want a quick start to the weekly therapy process.</i> - Access to online Relationship Checkup Questionnaires - Couple's interview - 90 min - Individual interviews for each partner - 55 min each - Intervention plan prepared by Dr. Curry (plan will be shared in subsequent sessions as scheduled with the couple) - 2 hrs.	975.  <i>\$375 deposit</i>
<b>PREMARITAL INTENSIVE PACKAGE - 5 HOURS + LUNCH BREAK</b> <i>Intended for couples who are hoping to strengthen their bond prior to marriage.</i> - 5 hours of skill-building to learn how to prevent future relationship issues - A take home package of tools and supplemental material	1750.  <i>\$750 deposit</i>
<b>ONE DAY INTENSIVE THERAPY PACKAGE - 5 HOURS + LUNCH BREAK</b> <i>Intended for couples who have already completed the assessment process and who want to address issues as quickly as possible.</i> - 5 hours of intensive therapy - A take home package of tools and supplemental materials	1750.  <i>\$750 deposit</i>
<b>TWO DAY ASSESSMENT &amp; INTENSIVE THERAPY PACKAGE - 10 HOURS + BREAKS</b> <i>Intended for couples who want to start the assessment and therapy process as quickly as possible.</i> - 3 ½ Hour Assessment Package plus 6 ½ hours of intensive therapy - A take home package of tools and supplemental materials	3450.  <i>\$1450 deposit</i>

<b>OTHER SERVICES</b>	
BETWEEN-SESSION PHONE CONTACT - Per 15 min	75.
LETTERS AND FORM COMPLETION - Per 30 min	150.

*By signing below the Client or Guardian 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*



## NEW CLIENT INFORMATION FORM

*Please allow approximately 30 – 45 minutes to complete this 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. Your information will remain confidential, so please answer as openly and honestly as possible. The more information we have, the better equipped we are to help.*

Today's Date: \_\_\_\_\_

### I. DEMOGRAPHIC INFORMATION

#### ***Patient Information***

Patient 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**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bigender ( <i>having two genders</i> )   | <input type="checkbox"/> Male   | <input type="checkbox"/> Transgender female<br><i>(non-identification with male sex assigned at birth)</i> |
| <input type="checkbox"/> Female   | <input type="checkbox"/> Non-Binary ( <i>unbounded gender</i> )       |  |
| <input type="checkbox"/> Gender fluid ( <i>identification is fluid/shifting between two or more genders</i> ) | <input type="checkbox"/> Omnigender ( <i>possessing all genders</i> ) | <input type="checkbox"/> Transgender male ( <i>non-identification with female sex assigned at birth</i> )  |
|   | <input type="checkbox"/> Other: _____                                 |  |

**Sexual Orientation**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asexual ( <i>lack of sexual or romantic interest in members of any gender or sex</i> ) | <input type="checkbox"/> Heterosexual ( <i>sexual or romantic interest in a member of the opposite sex or gender</i> ) | <input type="checkbox"/> Pansexual/Omnisexual ( <i>sexual or romantic interest for people of all genders &amp; sexes</i> ) |
| <input type="checkbox"/> Bi-Sexual ( <i>sexual or romantic interest in both men and women</i> )                 | <input type="checkbox"/> Lesbian ( <i>sexual or romantic interest in women by women</i> )                              | <input type="checkbox"/> Questioning ( <i>still exploring or unsure of sexual orientati</i> )                              |
| <input type="checkbox"/> Gay ( <i>sexual or romantic interest in members of the same gender or sex</i> )        | <input type="checkbox"/> Other: _____  |  |

**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.

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

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.***

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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