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

T. 949.258.9777
F. 949.258.9749
www.currygroup.org
contactus@currygroup.org

Policies and Procedures

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 therapy process, so you are fully informed prior to starting.

What to expect: The first session will involve an evaluation of your needs. During this time, you and your therapist can decide if we are able to provide you with the services you need in order to meet your treatment goals. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work together will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. On some occasions, the therapist may determine during the evaluation phase that there may be other resources or practitioners that are better suited to help a client. In such cases, the therapist will provide appropriate recommendations and referrals. If both you and your therapist decide to continue with therapy, we will typically schedule one session per week lasting approximately 50-55 minutes (depending on your therapist). Some sessions may be longer, or may occur more or less frequently.

Limitations to therapy: Therapy has been shown to have significant benefits for people, leading to better relationships, improved well-being, solutions to specific problems, and reduced feelings of distress. Working toward these benefits; however, requires active effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Remembering and talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions and propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions to change behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. Thus, we can make no guarantee about how the therapy process will be for you or that therapy will yield positive or intended results. In addition, individual therapy within our private practice setting is not advisable in the following situations:

- If there is active alcohol and/or drug addiction
- If you have a major mental illness that is untreated with medication or, if treated with medication, has been recurrent (schizophrenia, recurrent psychotic depression, delusional disorder, or bipolar I disorder with recurrent manic episodes). This does not include a past, successfully treated psychotic episode (e.g. post-partum depression with psychosis).
- If you are currently experiencing suicidal or homicidal thoughts, or have a history of serious harm inflicted on yourself or another person.

24-hour cancellation policy: 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 your therapist, 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 you pose an imminent danger to yourself or another person, we are allowed to disclose information to law enforcement personnel or hospital staff to keep you or the other person safe and coordinate your care.
- If you talk about events that lead us to believe that either 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.

Non-Involvement in Litigation: The ethics and rules of our profession preclude us from serving in a dual-role of therapist and evaluator. As your therapist, we will not be conducting a formal evaluation and therefore do not have a valid and reliable basis from which to provide an expert opinion to any third party. 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. *Written Statements of Opinion*. Similarly, we do not provide statements of opinion or recommendations in written letter, report, or forms, unless we are explicitly retained to provide a psychological evaluation. If an established therapy client requires evaluative services, we will provide appropriate referrals.

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 email or text message, nor do we discuss these matters outside of a scheduled appointment except in the instance of a true clinical emergency.

Emergency Procedures*:* In the event of a clinical emergency (such as acute thoughts of harming oneself or others or experiencing a traumatic life event) please 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.

Frequency of emergency contact between sessions. Please note that requests for emergency contact between scheduled sessions is expected to occur during true clinical emergencies only. In cases when a client requests frequent between-session contact, or more than one or two standard duration appointments per week, the client's continued treatment will be contingent on their acceptance of a higher level of care (intensive outpatient, partial hospital, or inpatient treatment), involvement of family members to monitor safety and compliance (if appropriate), psychiatric support with medication compliance, and/or other modifications of treatment to enhance the client's stability.

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

Consent to Treatment: I acknowledge that I have received and have read (or have had read to me) the introductory forms provided to me about the therapy I am considering. I have had all my questions answered fully. I understand that developing a treatment plan with my provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided. I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received.

By signing below, I acknowledge that I have read the above policies/procedures and am undertaking treatment with the Curry Psychology Group with full awareness and acceptance of the policies and procedures governing this practice:

_____ _____

Client or Parent/Guardian Signature Date

_____

Printed Name

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.

Fee Schedule

	DR. SHANNON CURRY, PSYD, MS	KARI A. FISHER, LCSW, MED, PPSC	DR. FRANCESCA PARKER, PSYD	SOPHIE CLAUSS, MA, LMFT
Therapy Services				
INITIAL INTAKE APPOINTMENT (60 or 90 min)	300. /400. (60/90 min)	200. /265. (60/90 min)	200./265. (60/90 min)	175./235. (60/90 min)
INDIVIDUAL THERAPY (ADULT OR CHILD)	275. (55 min)	200. (55 min)	175. (50 min)	150. (50 min)
FAMILY THERAPY / PCIT	300. (55 min)	200. (55 min)	200. (50 min)	175. (50 min)
Supplemental Services				
BETWEEN-SESSION PHONE, TEXT & EMAIL CONTACT Per 10-15 min	50.	40.	35.	30.
LETTERS AND FORM COMPLETION Per 30 min	150.	100.	100.	75.
SCHOOL VISITS/IEP MEETINGS Up to first 90 min (includes drive time)	-	350. (≤90 min)	-	300. (≤90 min)

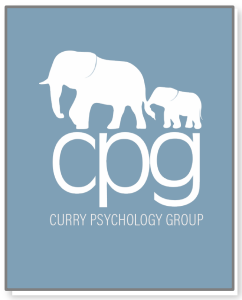
By signing below, the Client or Guardian indicates their understanding and agreement to the Curry Psychology Group's payment policies and fees as outlined in this document.

_____ _____

Signature of Client or Parent/Guardian *Date*

_____ _____

Printed Name *Relationship to Client*



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Credit Card Authorization Form

Please enter the card information you wish to keep on file for automatic deduction of your session fee, copayment, or insurance deductible (if applicable). The following credit and debit cards are accepted: Visa, MasterCard, Discover and AMEX.

Client Name: _____

Credit/Debit Card Information:

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

Name on Credit Card: _____

Card Number: _____

Expiration Date: _____

Security Code (3 or 4-digit code on card): _____

Billing Address:

Street: _____ City:_____

State: _____ ***Zip:** _____

Main Phone Number: _____

Email: _____

I, the cardholder, authorize fees charged by Curry Psychology Group in accordance with the billing agreement to be deducted from the credit or debit card listed above.

_____ _____

Cardholder Signature

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PSYCHOLOGY GROUP

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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

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

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? _____

_____

_____

_____

_____

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