Heart Healer
TREATMENT CENTER

Brad Gilbert MFT, CSAT, Director

CLIENT INFORMATION

Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Complete and check preferred method of contact.

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Text Message

☐ E-mail _____

*E-mail address may also be used to contact you with information about coming workshops, conferences, or just to send articles on therapy issues. Is this OK with you? ☐ Yes ☐ No

Work Phone _____ Job Title _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed How Long? _____

Mate's Name _____ Date of Birth _____

How did you find us? ☐ Therapist ☐ Friend ☐ Internet ☐ Other_____

Therapist Notes:

3436 American River Drive, Suite 17, Sacramento, CA 95864 | Brad@hearthealer,net
13405 Folsom Blvd, Building 200, Suite 220, Folsom, CA 95630 | 916-616-5227

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INFORMED CONSENT ADDENDUM FOR MIND TO MINDFUL CLIENTS

Fees/Payments

Co-pays and or deductible payments are due at time of service and are based on your insurance plan.

Additional Cancellations & Missed Sessions Policies

Consistency is important in the therapeutic process, but if you need to cancel an appointment, please contact me two (2) business days prior to the session or you will be responsible for paying for the missed session. (Exceptions include that you are physically sick, or there is an emergency.) You will be billed $80.00..

Please write down your credit card information and sign permission to use it for missed sessions.

Signature_____

Type of card _____

Name on card_____

Card number_____

Expiration Date _____CVV_____

Billing Zip Code_____

Email_____

The Nature of Counseling

The relationship between the client and psychotherapist is unique and special. This means that there **can be NO dual relationships** (i.e. being friends, attending functions together, bartering for services, etc). **This is mandated by the ethical code of my profession.**

Our first few sessions together will be an evaluation period as we get to know each other and understand the issues that brought you here. We then discuss treatment options and recommendations. The counseling process can be intense and painful. Sometimes clients feel worse before they feel better.

Lastly, referrals to other professionals (doctors, psychiatrists, etc.) may be required, and refusal to comply with my referral **may require me to terminate** our therapy relationship.

Outstanding Balances

I prefer to run a "payment at time of service" practice to avoid dealing with the extra overhead of billing clients. However, should an outstanding balance arise (i.e. "I forgot my checkbook", or "I forgot we had an appointment"), the payment **must** be paid before or at the following session.

There is a $20.00 fee in addition to the original check charge for all checks returned for insufficient funds. After 90 days with no payment or effort to make a payment arrangement, accounts may be turned over to the Retail Credit Association (RCA) for collection, which may adversely affect your credit rating.

Odds & Ends

I'll come and get you at the beginning of your appointment. Your time ends at ten minutes before the next appointment. I use this time to return phone calls and take a short break. Please be on time.

Confidentiality

Confidentiality will be maintained unless you have signed a written release of information to a specific individual or agency.

The following are exceptions to confidentiality between therapist and client in California:

1. If you disclose that you are suicidal, and after clinical assessment, it is deemed that there is a serious concern for your safety, your therapist is required to ensure you are safe by calling the police, hospital or family member, etc.

2. If you disclose that you are homicidal, and after clinical assessment, it is deemed that you are of imminent homicidal threat to an identified potential victim, your therapist is required to and has a duty to warn the potential victim and contact the police.

3. If you disclose that you have abused any person 65 or older or a dependent/vulnerable adult, your therapist is mandated to report the abuse to Adult Protective Services.

4. If you disclose that you have abused or neglected a minor (defined as any person under the age of 18), your therapist is mandated to report the abuse or neglect to appropriate state agencies.

5. Effective as of January 1, 2015, if you disclose that you have downloaded, streamed or accessed images of a minor engaged in an act of obscene sexual conduct, including child pornography, your therapist is mandated to report that disclosure to appropriate state agencies. **This means that if you disclose to me that you or anyone you know has viewed child pornography or other images of obscene sexual conduct involving a minor, I am obligated by state law to report your disclosure to appropriate state agencies.**

Initial _____ Date _____

Your initials above signifies that you understand and agree with the limitations of confidentiality.

I may decide that consultation with a colleague will help in your treatment. If I do this, your name will not be used.

Notice of Termination

You are not obligated to see me for any specific number of sessions. **It is important, however, to give me one session's notice should you wish to discontinue treatment**. What I want to avoid is a situation where you cancel and then do not reschedule without an explanation. A clean ending will be important for the both of us.

Weekends, Holidays & Vacations

I check phone messages between the hours of 9:00 a.m. – 7:00 p.m. If I am out of town or on vacation, I may have another therapist checking my messages and returning your call if I am unable. If I suspect that you may be calling while I am away, I will advise that therapist of pertinent facts about you.

Your signature below signifies you are granting permission for such sharing of information.

I understand and agree to the terms specified above:

_____ _____

Signature **Date**

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Client Intake

Name, age and relationship of persons living in your household:_____

_____

_____

_____

Names and ages of children:_____

_____

_____

If not living with you, where do they live and how often do you see them?:_____

_____

How long have you lived in this area:_____

Person to contact in case of emergency:_____

_____

Address City State Zip Code Phone #

Whom may I thank for this referral:_____

Have you ever been seen by a counselor/therapist/psychiatrist before:_____

List and Give Dates:_____

_____

Why did you terminate?:_____

Have you or do you participate in any 12 step program? If yes, which ones and when?

Why did you stop attending?: _____

_____

Are you taking **any** medication now?_____ List:_____

_____

List all tranquilizers or anti-depressants you have taken in the past: _____

_____

Have you ever been hospitalized for psychiatric (emotional) reasons? If so, why and when? _____

Have you ever thought about or attempted to kill yourself; when?:_____

_____

Have you ever physically abused yourself?:_____ Explain:_____

_____

Have you ever been sexually molested? (Include attempts):_____

_____

Have you ever been raped? (Include attempts):_____

_____

Has your partner been raped?:_____ Were you in a relationship with him/ her at the time?: _____

Have you ever been a victim of a violent crime?:_____

_____

Have you ever been involved in a battering relationship? Explain: _____

_____

Have you ever had an abortion or has your child been aborted?:_____

What effect has that had on you?:_____

_____

Name and address of your physician:_____

_____

Address City State Zip Code Phone Number

Have you ever had any of the following illnesses? Please answer yes or no and give the date(s):

Allergies (name)_____ Liver trouble_____
Seizures_____ Back injury/chronic pain_____
Thyroid trouble_____ Asthma_____
Fainting spells_____ Head injuries_____
Heart trouble_____ Gastritis/ulcers_____
Cancer_____ High Blood Pressure_____
Frequent headaches_____ Anemia_____
Diabetes_____ Kidney Disease_____
Anxiety attacks_____ PMS_____
Frequent yeast infections_____Compulsive overeating_____
Life threatening illness(name)_____
Other_____

SUBSTANCE USE

What is your history and current use/abuse of the following substances: alcohol, illegal drugs, prescriptions drugs, tobacco and caffeine?:_____

_____

PRELIMINARY BACKGROUND INFORMATION

How were you disciplined?_____

_____

Were you ever physically abused as a child by anyone?:_____

_____

How many times have you been married?:_____ How long?: _____

How many other significant relationships?:_____ How long? :_____

Are you in a significant relationship now?:_____ If yes, how long?_____

How would you describe your relationship?_____

Do you have any of the following symptoms? On the following two pages, please check the symptom and describe how often it is a problem it is for you. If it has only been a problem recently, indicate how long it has been a problem.

Are These True for you?

Are These True for You?	Never	4x/yr or less	More than 4x/yr	1xmo. Or more	1x/wk or more
Have too much energy					
Feel down-hearted and blue					
Have crying spells or feel like having them					
Have trouble sleeping at night					
Sleep more than 8 hours in a 24 hr. period					
Temper is explosive					
Isolate from others					
Have phobias or fears					
Feel that people control your actions					
Feel that you can read other peoples' minds					
Hear voices when no one is there					
Enjoy time alone					
Have homicidal thoughts or attempts					
Use sex to make you feel better					
See visions					
Spend time with you friends					
Have special powers					
Vomit or take laxatives to control weight					
Feel that people can read your mind					
Lose money gambling					
Feel that people are out to harm you					
Eat too much or too little					
Enjoy sex					
Notice that you are losing weight					
Have trouble with constipation					
Heart beats faster than usual					
Get tired for no reason					
Have difficulty concentrating					
Find it difficult to do the things you used to					
Restless and can't keep still					
Feel hopeful about the future					

Are These True for you?

Are These True for You?	Never	4x/yr or less	More than 4x/yr	1xmo. Or more	1x/wk or more
More irritable than usual					
Find it difficult to make decisions					
Feel that you are useful and needed					
Feel that others would be better off if you were dead					
Have intense mood swings					
Stay up all night or for days in a row					
Have flashbacks to past painful experiences					
Have nightmares					
Have lapses of memory					
Say or do things that are out of character					
Routinely work more than 50 hrs. per week					
Spend money to make you feel better					
Concerned about your weight					
Life is pretty full					

CURRENT SITUATION

Please state briefly what is troubling you now.

_____

_____

_____

_____

What would you like to accomplish in therapy?_____

_____

_____

_____

_____

Thank you for filling out this form. It will be very helpful in your evaluation. Add any additional comments below that you would care to make._____

_____

_____

_____

_____

_____

_____

_____

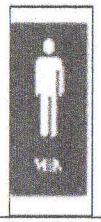
_____

On page 9 & 10, there are life circumstances that can cause stress to you or other significant people in your life. They are not necessarily negative, but may be viewed as negative by some people in society. Put an "X" in the appropriate space if these circumstances have occurred.

You can use the Comments section to give more detail (identify which sibling, etc.) or add other significant people who qualify under these classifications.

The Female symbol on the top row refers to the maternal side of your family and the Male to the paternal side. Even if the stressors happened before you were born they may have impacted your parents.
Do your best. You don't have to interview your whole family. just what you know about.

	You	Mother	Father	Brother	Sister	Spouse/Mate	Children	Stepchildren	In-Laws		Grandfather	Grandmother	Aunt	Uncle		Grandfather	Grandmother	Aunt	Uncle	Comments
Anorexic																				
Compulsive Eater																				
Bulimic																				
Compulsive Gambler																				
Workaholic																				
Interracial Relationship																				
Affairs																				
Adoption																				
Miscarriages																				
Stillborn Births																				
Infertility																				
Drug Abuse																				
Alcoholism																				
Mental Illness																				
Psych. Hospital																				
Severe Depression																				
Attempted Suicide																				
Committed Suicide																				
Homosexual																				
Sent to Prison																				

	You	Mother	Father	Brother	Sister	Spouse/Mate	Children	Stepchildren	In-Laws		Grandfather	Grandmother	Aunt	Uncle		Grandfather	Grandmother	Aunt	Uncle	Comments
In & Out of Jail																				
Sexual Addictions																				
Victim of Sexual Abuse																				
Victim of Physical Abuse																				
Violent to Family																				
Life Threatening Illness																				
Chronic Serious Illness																				
Accidental Death																				
Victim of Violent Crime																				
Perfectionist																				
Explosive Behavior																				
Permanent Disability																				
Foster Care																				
Compulsive Spender																				
Miser																				