



Client Information

Client Name (Last)_____ (First)_____
(M)_____

Age_____ Birthdate_____ Sex_____

Address_____

City/State/Zip_____

Phone #:_____

Ok to call, text, leave messages?_____

Marital Status Single Married Divorced Separated Widowed cohabitating

Email address: _____

Education: (Highest degree/grade Completed)

Current Household

Who lives in your household?

Name/age/relationship:_____

Name/age/relationship_____

Name/age/relationship_____

Emergency Procedures

Notify in case of emergency (Name, relationship, phone number for contact)

Print Name

Signature

Date

Occupation

How long? _____ Level of daily stress: **1**-----**10**

Have you recently considered changing occupations?

What motivated this thinking?

Health Data

Your Physician (Full Name):

Clinic Name

Address

Date of most recent physical:

Do you have any current medical problems (including any infectious diseases)? yes no

Please describe:

Are your medical problems being treated? _____ If yes, by whom? _____

Have you ever had a drug allergy or sensitivity? yes no If yes, to what drug: _____

Current Medications:

Prescribing MD: _____

Past trials of psychiatric medications:

Chemical Use History

Have you ever drank, smoked cigarettes, or used mood altering substances? yes no

If yes, what, when, how long? Why?

Do you drink alcoholic beverages? Yes No

If yes, what is your motivation for drinking?

Do you use any mood altering substances including prescriptions? Yes No. If yes, what/how long?

If yes to alcohol, what do you drink? Beer Wine hard liquor.

How long have you drank this? _____

How often do you drink? Daily 3-5 times weekly 1-2 times weekly Less frequently

Do you sometimes drink more than you had planned? Yes No

Have family and friends ever expressed concern about your drinking? Yes No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.? Yes No

Have you ever been treated for drinking, chemical dependency or gone to AA? Yes No

Have you ever had periods where you were unable to remember what happened when you were drinking?
 Yes No

Have you ever overdosed? yes no

Do you use nicotine? yes no If yes, how much and for how long: _____

Counseling and Psychiatric History:

(Dates of treatment, hospitalization, provider/treatment and outcome, etc.)

Outpatient treatment Partial hospitalization Inpatient hospitalization Residential treatment

Name of Facility/Doctor/Address:

Any additional Info:

Trauma History:

(abuse, accidents, injuries, illness, losses, death of loved one, other)

Abuse/Mistreatment History:

History of abuse: no yes; If yes: physical sexual verbal/emotional psychological

Legal Action: no yes

Perpetrator/s of abuse:

When, where, a few details of what happened:

Family Mental/Behavioral Health History:

(Include family history of suicide/homicide)

Maternal side: depression anxiety bipolar eating disorder alcoholism drugs
suicide codependency

Paternal side: depression anxiety bipolar eating disorder alcoholism drugs
suicide codependency

Birth Order _____

Parents Married/separated/Divorced? _____

Siblings _____

Bullying (stranger/family/acquaintance)

Family/Parental Anger Style? (How did/does your family express anger?)

Emotional Expression style? (How did/does your family express emotions?)

Did your family of origin include any of the following: dysfunction disordered thinking/behavior
 highly critical rejection abandonment skepticism perfectionism/unreasonable expectations
 enmeshment "free range" parenting excessive pride/ego/self protection shaming
 defiance/rebellious pattern ineffective use of negative emotions (ex:anger) controlling/bossing/nag
 critical observations use of denial blaming lying/secrecy/defensive broken trust

Are you able to name a role you played in your family of origin?

(Ex: hero, scapegoat, black sheep, enable-in-training, crazy one, bully, etc.)

Family Hx of Schizophrenia/Psychotic Disorder/Psychotic Episode? Yes No

Additional mental health information: (who, treatment, other diagnoses)

Other Factors that Impact Client's Life

(e.g. cultural issues, military, spiritual and/or legal issues)

Legal issues:

No Yes

(Describe if yes)

Military: No Yes

Symptom Checklist

Circle and rate the intensity of symptoms present in the last 1-3 months:

None: This symptom is not present now.

Mild: Impacts quality of daily life, but no/little significant impairment of day to day functioning.

Moderate: Significant impact on quality of life and/or day-to-day functioning.

Severe: Profound impact on quality of life and/or day to day functioning.

Abbreviations: N---M--Mo----Sev

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Depressed Mood

Increased/decreased appetite

Low Energy

Unplanned weight gain/weight loss

Sleep disturbance

Compulsive masturbation

Dissociation-feeling disconnected from one's self

Paranoid thoughts/general paranoia

Hyperactivity

Poor concentration or Indecisive

Bingeing and/or purging

Unshakable guilt and/or shame

Over-exercising

Decreased Sex Drive

Excessive worrying

Unresolved guilt

Loss of functioning in any area of life

Impulsive actions/speech

Irritability

Anger outbursts

Isolating from others/social interaction

Periodic increased energy with agitation

Nausea/Acid indigestion

Daily Unmanageable Stress Level

Anxiety in social situations

Hallucinations

Self-mutilation/cutting

Racing thoughts

Low self-worth

Restlessness

Nightmares

Lack of emotional responsiveness

Negative voices inside

Daily drinking or drug use rituals

Losing train of thought

Resentments/bitterness

Mood swings

Easily Distracted

Disorganized

Intrusive memories of trauma

Restricting food intake

Hopelessness

Feeling a need/compulsion to use/do something to feel better

Marital problems/conflicts

Grief/loss

Panic Attacks/symptoms of panic

Extreme fears of people, places, things, or situations

Suicidal thoughts

Headaches

Unreasonable expectations

Anxiety connected to most areas of life

Loneliness

Work related conflicts/disagreements

Viewing Pornography

Keeping alcohol/drugs in unlikely places

Problems at home

Attempted suicide in the past

Perfectionism

Rigid ideas/views/behavior

Briefly describe how the above symptoms impair your ability to function:

Treatment Contract/Registration

WELCOME! The most important goals of therapy are to help you feel better, function better, and to be able to manage your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family and/or supportive friends during periods of increased stress and escalated emotions. Above all, it is important that you assume the primary responsibility for your needs. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are 50-60 minutes. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also, this is a courtesy to others that may be waiting. If

you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality

Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents.

Emails and text messages do not provide sufficient confidentiality. You may put things in writing to us, and request that we do the same for you; however, we cannot guarantee that our security will never be breached.

The following is not a legal exception to your confidentiality; however it is a policy you should be aware of if you are in COUPLES or PARTNER THERAPY with Veritas: If you or your spouse/partner have some individual sessions as a part of couples therapy whatever you say in those individual sessions will be considered to be a part of couples therapy and may be discussed in our joint sessions. Do not disclose to the counselor anything you wish to keep secret from your partner.



Client signature: _____ Date _____

Parent Signature _____

Office Hours and Cancellation Policy:

Therapy time is valuable to all involved and mutual respect is important to maintain the therapeutic relationship. You can make appointment changes by calling the office and leaving a message with your counselor. Clients who arrive late, your therapy will end at the normal scheduled time. You must pay in full for that full session. If you cancel with less than a 24-hour notice for any other reason than an emergency due to sickness or an emergency you must pay for that session. Clients who no-show or late cancel (less than a 24 notice), three times will be notified that their case will be closed. You are responsible for paying for your session at each visit.

Veritas will bill the client/s pro-rata for reading materials they send, writing on their behalf, and phone conversations or messages of over 15 minutes in length.

I understand cancellations or changes of an appointment must be made at least 24 hours in advance or I will be charged the listed fee for my scheduled session.



Client Signature _____ Date _____

Parent signature _____

Consultation and Supervision: To provide you with the best possible service, your counselor must engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call Veritas during normal business hours and then the Crisis Connection at 612-379-6363 after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Fees, Phone Calls and Reports: Fees are as follows: \$75.00 for individual sessions and \$100.00 for couple’s sessions and \$125.00 for family sessions. Fees for group therapy vary by program. Every 15 minutes past the counseling hour will be charged pro rata to the client. In-home sessions have an additional fee of .50 cents per mile to and from the client location with a \$10.00 minimum charge due also at the end of each session.

Full payment is due at the end of the therapy hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. unless it becomes time consuming. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. No show/late cancellation individual therapy appointments will be charged a \$50.00 fee. No show/late cancellation couples therapy appointments will be charged a \$75.00 fee. No show/late cancellation family therapy appointments will be charged a \$100.00 fee. Please note: All no-show or late cancellation fees are due the day of your next appointment. If accrued fees are not paid and cannot be paid the appointment may be rescheduled for a time after payment is received.

In the case of an unpaid bill, Veritas reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection will be added to your bill. Return check fee is \$35 and will be billed to you.

Record-keeping, Requests from Third Parties for Records, Testifying Regarding Records, and Related Costs.

Veritas keeps very brief records including only that you have been here, interventions that happened in session, and topics and goals discussed. You have a right to a copy of your file at any time. You have the right to request that we correct any errors in your file, and you may provide a copy of that file to any health care provider at any time. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing.

If a child or children are involved, you or your non-health care advisors may not subpoena our documents or use as evidence in any proceeding any communication or documents related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to give identical documents to the opposing party.

If we are forced to further document or respond to information requests, meet with your representatives, or testify in court our fees are \$200.00/hour, portal to portal, plus all expenses, half day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document.

Services NOT Offered.

We are not qualified and we do not offer the following services: 1. Custody Evaluation 2. Visitation Recommendations 3. Disability Evaluation or Recommendation 4. Services requiring testimony in legal proceedings.

Note: Therapy ends when a subpoena arrives. We will attempt to legally resist a subpoena request to give your confidential records to legal counsel. We prefer to send directly to the Judge. Therapy summarization documents for legal purposes require written client release and cost \$250 per request.

I understand and agree to abide by the policies stated above.



Client Signature _____ Date _____

Parent Signature _____ Date _____

Health Information Privacy Practices

I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Print name _____



Signature _____ Date _____

Parent Signature _____

Bill of Rights/Registration

BILL OF RIGHTS

Consumers of services offered by Marriage & Family Therapists in State of Minnesota have the right: 1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law. 2. To examine the public records maintained by the Board of Marriage and Family which contain the credentials of the practitioner. 3. To obtain a copy of the rules of conduct from the Minnesota Board of Marriage & Family. 4. To report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the Minnesota Board of Marriage & Family. 5. To be informed of the cost of professional services before receiving

the services. 6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client’s informed, written consent, except for the following:

- a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
 - b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
 - c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
 - d. In the event of a client’s death, the spouse or parents of the deceased have a right to access the client’s records.
 - e. The practitioner must produce records or testimony in response to a court order and potentially to a subpoena.
 - f. Parents or legal guardians of a non-emancipated minor client have the right to access their child’s records.
 - g. Case discussions with other staff through case management; consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
8. to respectful, considerate, appropriate, and professional treatment.
9. To see information in his/her record upon request.
10. To be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
11. To be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand.
12. To discuss needs, wants, concerns, and suggestions with the practitioner.
13. To be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Signature acknowledges receipt and understanding of these rights.

★
 Signature _____ Date _____

Signature of Parent/Guardian _____ Date _____

Welcome to Veritas!

We look forward to what God has in store for you!