Heather R. Roberts, MA, LMFT, LPC
Licensed Marriage and Family Therapist
Licensed Professional Counselor
26113 Oak Ridge Drive Suite C
The Woodlands, TX 77380
Phone: 281.475.5957
Email: hrr004@gmail.com

INFORMATION AND INFORMED CONSENT

Date:_____

CLIENT Name: _____
LAST FIRST MI

Age: _____ Birthdate: ____/____/____ Male_____ Female_____

Address:
_____
STREET CITY STATE ZIP
Phone:
_____
HOME WORK CELL OTHER

E-mail address:_____

What is the best way to reach you? _____

Who referred you to this office? _____

Do I have your permission to thank the referral source for referring you? Y N

Marital Status: _____ Single _____ Married _____Committed Partnership
_____ Separated _____Divorced _____Widow(er)

Spouse/Partner's Name: _____ Age: _____

On a scale of 1 – 10, how well would you rate your relationship? _____

Person to contact in case of emergency: _____

Relationship to Client: _____ Phone Number(s): _____

What is your highest education level achieved?_____

Occupation: _____#Years_____

Employer: _____#Years_____

Previous Employer: _____#Years_____

Religion: _____ Church/Mosque/Synagogue Affiliation: _____

Are any of the following conditions a problem or struggle for you at this time? Check all that apply.

□ Anxiety
□ Anger/Conflict
□ Stress
□ Job/School Issues
□ Marital Issues
□ Nervousness
□ Relationship to Parent/child
□ Self Esteem
□ Loss of Faith in God
□ Irrational Fears
□ Feelings of Guilt
□ Rage
□ Family/Relationship Issues
□ Depression
□ Sexual Problems
□ Grief
□ Lack of Purpose
□ Loneliness
□ Loss of Hope
□ Loss of Meaning in Life
□ Loss of Work/Job
□ Substance abuse
□ Religious Doubts
□ Thoughts of Harm Self/Others
□ Self Injury
□ Blended Families
□ Other_____
_____
_____
_____
_____

What do you consider to be some of your strengths? _____
_____
_____

What are some areas in your life that you would like to improve? _____
_____
_____

How often do you drink alcohol?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never ___

How often do you engage in recreational drug use?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never ____

Substances used_____

MEDICAL/PSYCHOLOGICAL

Name of Psychiatrist: _____ Date of last exam: _____

Primary Care Physician: _____ Date of last exam: _____

Current illnesses and medications:_____
_____
_____

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

How many times a week do you generally exercise? _____

What types of exercise do you enjoy? _____

Are you currently experiencing any chronic pain? ____ Yes ____ No If yes, please describe: _____

Have you ever received psychotherapy or counseling in the past: (circle) Yes No

When:_____ Name of treating Therapist:_____

PLEASE CAREFULLY READ THE ATTACHED STATEMENT OF POLICIES. THEN READ AND SIGN THE INFORMED CONSENT BELOW. PLEASE KEEP THE STATEMENT OF POLICES FOR YOUR RECORDS.

INFORMED CONSENT

I, _____, (please print name) have read and fully understand the information provided in the Statement of Policies document regarding the various services provided by this office and the potential risks and benefits of outpatient psychotherapy. I also understand the obligations and limitations of confidentiality within the context of the client/therapist relationship. I agree to make payment at the time of service. I agree to cancel appointments only in the event of extreme necessity and I understand that I will be charged $65.00 unless I provide 24 hours advance notice. I understand that I can leave therapy at any time and if I choose to do so will be assisted by the therapist in finding other clinical resources if any are desired.

By signing this document, I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate treatment I will discuss termination before ending treatment.

Before you sign below, please ask any questions you may have of this document. **Your signature acknowledges agreement and understanding:**

_____

Print name of Client

_____

Client Signature Date

_____

Spouse Date

_____

Parent/Legal Guardian Signature Date

_____

Signature of Therapist Date

COMMUNICATION AND YOUR PRIVACY

Please know that despite security efforts, all electronic communication, including email and cell phone (voice or text) carry an inherent risk of being accessed by unauthorized people, which can compromise your privacy. Even communication about scheduling carries a risk to your confidentiality because it conveys the fact that you are in counseling. Please read and initial the items below to indicate your understanding and consent regarding our communication.

_____1. If I convey sensitive personal information by phone or email/text, Heather R. Roberts, MA, LMFT, LPC can assume that: a) I am making an informed decision accepting the privacy risk, and b) I am comfortable with Heather R. Roberts, MA, LMFT, LPC responding to me by the same communication method, unless I indicate otherwise.

_____2. I consent to using email and text messaging for scheduling and other administrative (nonclinical) purposes.

_____3. I consent to receiving appointment reminder via emails and/or text messaging.

_____4. I consent to receiving email and/or text receipts for credit card payments.

Please sign below indicating your approval to communicating via email and text.

_____

Signature of Client Date

_____

Signature of Therapist Date

If you are **NOT** comfortable communicating with Heather R. Roberts, MA, LMFT, LPC via email or text, we can do so via phone calls. Please sign below to indicate your preference to **NOT** communicate via email or text messaging.

_____

Signature of Client Date

_____

Signature of Therapist Date