

Julie Wells, M.S., Licensed Marriage, Family Therapist #79760
7545 Irvine Center Drive, Suite 200, Irvine, CA, 92618
949-230-8554

NEW CLIENT ASSESSMENT

Date: _____

Partner 1 Name: _____ Cellular Phone: _____

Email Address: _____

Partner 2 Name: _____ Cellular Phone: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Contact in Emergency Situation: _____

Telephone Number: _____ Relationship: _____

What concern/s brings you to counseling?

How did you find me? _____

(Psychology Today, Theravive, Google Search, Yelp, Referral, etc.)

To be completed if Client is a Minor:

Parent/Guardian: _____

Contact Information: _____

If parents are divorced, who has legal custody? _____

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Credit Card Authorization

I, _____, authorize Julie Wells to charge my credit card for retainer purposes and any unpaid balances and fees associated with my Psychotherapy.

Any fees that are not paid at the time services are rendered will automatically be charged to my credit card. A receipt of the charge will be mailed to me.

Name as it appears on card

Type of Card

Card Number

3 or 4 digit code

Expiration Date

Phone Number

Billing Address for Statement

City, State, Zip

Signature

Date

Julie Wells, M.S., Licensed Marriage, Family Therapist
7545 Irvine Center Drive, Suite 200, Irvine, CA 92618
949-391-3505 Julie@juliewellstherapy.com

CONSENT FOR TREATMENT

I, _____, authorize and request that Julie Wells, M.S., Licensed Marriage, Family Therapist to provide psychological assessments, examinations, treatment, and/or diagnostic procedures which are advisable during the course of my care as a client.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that, at times, I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I understand that my participation in psychotherapy is completely voluntary and that I may terminate psychotherapy at any time.

I understand that the purpose of these guidelines is to clarify the nature of our professional relationship.

I understand that I can obtain a copy of this informed consent by downloading it from the website of Julie Wells, found at www.therapyinirvine.com.

I understand that I may receive a copy of the signed consent page upon demand.

My signature below indicates that I have read and fully understand the information provided in this informed consent and I agree to abide by its terms during our professional relationship.

Client's Signature

Date

Client's Signature

Date

Parent/Guardian's Signature (if minor)

Date

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Date

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HIPPA Acknowledgment

I have been given the opportunity to read the HIPPA Notice of Privacy Practices.

Client Signature

Date

Client Signature

Date

Parent Signature For Minor Client

Date

MEDICAL HISTORY

Name: _____

Currently under a medical physician's care? YES/NO

If YES, please describe current medical condition/s: _____

Medications currently used: circle if NONE

Medication	Dosage	Dr. Prescribing	Why Prescribed
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling or Chemical Dependency Treatment/Services: NONE

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____

CHEMICAL DEPENDENCY ASSESSMENT

Have you ever attempted to reduce your alcohol intake? Y N

If yes, what was the outcome? _____

Do family members/friends ever complain about your drinking behaviors? Y N

Have you lost friends or alienated family members due to your drinking behaviors? Y N

Have you ever been reprimanded at work due to your drinking behavior? Y N

Are you currently using medical marijuana? Y N

Are you currently using marijuana for recreational use? Y N

(NOTE: ONLY USE THIS FORM FOR COUPLES COUNSELING)

PARTNER 2 MEDICAL HISTORY

Name: _____

Currently under a medical physician's care? YES/NO

If YES, please describe current medical condition/s: _____

Medications currently used: circle if NONE

Medication	Dosage	Dr. Prescribing	Why Prescribed
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_____	_____	_____	_____
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_____	_____	_____	_____
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Previous Counseling or Chemical Dependency Treatment/Services: NONE

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful (Y/N)
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_____	_____	_____	_____
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_____	_____	_____	_____
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