
**Client Information**

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

Age_____ Birthdate_____ Sex_____

Address_____

City/State/Zip_____

Phone #_____

Ok to call, text, leave messages? _____

Email address: _____

Current year in school?

_____

**Current Household**

Who lives in your household?

Name/age/relationship:_____
_____

Name/age/relationship_____
_____

Name/age/relationship_____
_____

Name/age/relationship_____
_____

**Emergency Procedures**

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

_____
_____
_____

Client Signature:

_____

Parent Signature:

_____

Date_____

**Occupation**

_____
_____
_____

How long?_____Level of daily stress**: 1**----------**10**

Have you recently considered changing occupations?

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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/ticketed for alcohol related charges: UD, possession, consumption, purchase, fighting, 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 mental health 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** (mom) side: ____depression ____anxiety ____bipolar ____eating disorder ____alcoholism ____drugs ____suicide ____codependency

**Paternal** (dad) 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?)

_____

Any inappropriate/unwanted sexual expression in the home? ___ Yes ___ No
Any sexual identity confusion? ___ Yes ___ No

Does 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 play in your family of origin?

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

_____

Family History 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

(Describe if yes)_____

Cultural issues: __No __Yes

(Describe if yes)_____

Spiritual beliefs/practices: (please include how long, where learned, any memberships, any rituals, current role it plays in your life).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Presenting situation:**

(What brings you to counseling? Include reason for making appointment, precipitating events, onset, course of symptoms, etc.)

**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

Abbreveations: N----M----Mo----Sev

| | |
|---|---|
| **Depressed Mood** | **Dissociation-feeling disconnected from one's self** |
| **Increased/decreased appetite** | **Paranoid thoughts/general paranoia** |
| **Low Energy** | **Hyperactivity** |
| **Unplanned weight gain/weight loss** | **Poor concentration or Indecisive** |
| **Sleep disturbance** | **Bingeing and/or purging** |
| **Compulsive masturbation** | **Unshakable guilt and/or shame** |

| | |
|---|---|
| **Over-exercising** | **Easily Distracted** |
| **Decreased Sex Drive** | **Disorganized** |
| **Excessive worrying** | **Intrusive memories of trauma** |
| **Unresolved guilt** | **Restricting food intake** |
| **Loss of functioning in any area of life** | **Hopelessness** |
| **Impulsive actions/speech** | **Feeling a need/compulsion to use/do something to feel better** |
| **Irritability** | **Marital problems/family conflicts** |
| **Anger outbursts** | **Grief/loss** |
| **Isolating from others/social interaction** | **Panic Attacks/symptoms of panic** |
| **Periodic increased energy with agitation** | **Extreme fears of people, places, things, or situations** |
| **Nausea/Acid indigestion** | **Suicidal thoughts** |
| **Daily Unmanageable Stress Level** | **Headaches** |
| **Anxiety in social situations** | **Unreasonable expectations** |
| **Hallucinations** | **Anxiety connected to most areas of life** |
| **Self-mutilation/cutting/picking/harming self** | **Loneliness** |
| **Racing thoughts** | **Work related conflicts/disagreements** |
| **Low self-worth** | **Viewing Pornography** |
| **Restlessness** | **Keeping alcohol/drugs in unlikely places** |
| **Nightmares** | **Problems at home** |
| **Lack of emotional responsiveness** | **Attempted suicide in the past** |
| **Negative voices inside** | **Perfectionism** |
| **Daily drinking or drug use rituals** | **Rigid ideas/views/behavior** |
| **Losing train of thought** | |
| **Resentments/bitterness** | |
| **Mood swings** | |

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

_____

_____

_____

_____

_____

_____

**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. 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. Parents do have legal status to inquire into their minor child's counseling disclosures however, parents should keep in mind that trust between the counselor and adolescent/child client is imperative for healing to progress. 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 the security of text or email.

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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.

***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.***

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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: $50.00 for individual sessions and $75.00 for couple's sessions and $100.00 for family sessions. Fees for group therapy vary by program.

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.***

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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_____

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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!**