LifeStyles Family Counseling and Consultation, Inc.
DBA: LifeStyles Counseling & Consultation
8350 Archibald Ave. Suite 100
Rancho Cucamonga, CA 91730
www.lifestylescc.com
(877) 288-5221

# PATIENT INFORMATION FORM

## CONTACT INFORMATION:

Name: ____________________________________________

Address: __________________________________________

__________________________________________________

Tel.: Home: ____________________ Work: ____________________

Cellular: ____________________ Email: ____________________

| ***You may contact me at:*** | ***General Message OK*** | | ***Detailed Message OK*** | |
|---|---|---|---|---|
| At Home | Yes | No | Yes | No |
| At Work | Yes | No | Yes | No |
| On Cell | Yes | No | Yes | No |

Emergency Contact Person: ____________________________________

Phone: ____________________ Relationship: ____________________

## PERSONAL INFORMATION

Relationship status: ____________________ Gender: Male Female

Date of Birth: ____________________ Certification#: ____________________

Employed: Yes No Part time Full time

Employer: ____________________________________

Student: No Part Time Full Time

Names and ages of your children:

__________________________________________________

__________________________________________________

__________________________________________________

## REFERRAL INFORMATION

Referred by: ____________________________________________

May I thank the person who referred you? Yes No

Name of Health Insurance: ____________________________________

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**In case of emergency, please notify one of the following three people:**

**May I have your permission to inform one or all of these people if you are ever in danger?**

Yes ___________________ No __________________

1. ______________________________________________________________________

| Name Address | Daytime Phone | Evening Phone |
|---|---|---|

2. ______________________________________________________________________

| Name Address | Daytime Phone | Evening Phone |
|---|---|---|

3. ______________________________________________________________________

| Name Address | Daytime Phone | Evening Phone |
|---|---|---|

This questionnaire supplements previous informed consents.

_________________________________ _________________________
Your Signature Date

_________________________________ _________________________
Your Signature Date

Child & Adolescent Assessment
LifeStyles Family Counseling and Consultation, Inc.

# I N T A K E F O R M-Child/Adolescent

*Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.*

**Client's Name:**

________________________________________________
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: Male Female

**Name of parent/guardian (if you are a minor):**

Mother________________________________________________
(Last) (First) (Middle Initial)
Occupation______________________/Company_________________________________

Father________________________________________________
(Last) (First) (Middle Initial)
Occupation______________________/Company_________________________________

Marital Status of Parents:
Never Married Partnered Married Separated Divorced Widowed

Number of Children: __________

**Residing Address of child:**

________________________________________________
(Street and Number)

________________________________________________
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg? Yes No

Cell/Other Phone: ( ) - May we leave a msg? Yes No

**Referred by**: ______________________________________________

Child & Adolescent Assessment
LifeStyles Family Counseling and Consultation, Inc.

(a) What school does your child attend and what grade is s/he currently in?
______________________________________________________________________

(b) Does your child have current or a past history of IEP or 504 services? Yes No
If Yes, provide date of most recent IEP, specific services and diagnosis: ______________
______________________________________________________________________

(c) Is your child currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

(d) Has he/she had previous psychotherapy?
No Yes, at previous therapist's name_______________________________________

(e) Is your child currently taking prescribed psychiatric medication (antidepressants or others)? Yes No
If Yes, please list: ____________________________________________________

(f) If no, has your child been previously prescribed psychiatric medication?
Yes No
If Yes, please list: ____________________________________________________

(g) Has your child been removed from your home and placed in foster care, with a relative, family friend, group-home or with approved identified person for any reason?
Yes No
If Yes, please indicate where and the dates of placement: ___________________________
______________________________________________________________________
______________________________________________________________________

(h) Has your child been incarcerated in juvenile hall: Yes No
If Yes, please indicate the age of your child & explain why incarcerated: ______________
______________________________________________________________________
______________________________________________________________________

**HEALTH AND SOCIAL INFORMATION**

*Provide the date of your last physical by your primary care physician (MD):
Date:_____________ Doctor's Name: _________________________________

1. How is your child's physical health at present?

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
______________________________________________________________________

3. Has your child had any problems with their sleep habits? No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other ______________________________________________

4. Is your child having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

5. Has your child experienced significant weight change in the last 2 months?
No Yes
If Yes, please indicate the specific weight lost/gained: ______________________________

6. Has your child had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Has he/she had them in the past?

Frequently Sometimes Rarely Never

7. Has your child inflicted pain on self (self harming behaviors)?
______________________________________________________________________________
______________________________________________________________________________

8. Has your child made threats to harm others or has harmed others?
______________________________________________________________________________
______________________________________________________________________________

9. In the last year, has your child experienced any significant life changes or stressors?
______________________________________________________________________________

10. Does your child currently or has a history of substance use?
______________________________________________________________________________
______________________________________________________________________________

Child & Adolescent Assessment
LifeStyles Family Counseling and Consultation, Inc.

**Has your child ever experienced:**

| | | |
|---|---|---|
| Extreme depressed mood | yes | no |
| Wild Mood Swings | yes | no |
| Rapid Speech | yes | no |
| Extreme Anxiety | yes | no |
| Panic Attacks | yes | no |
| Phobias | yes | no |
| Sleep Disturbances | yes | no |
| Hallucinations | yes | no |
| Unexplained losses of time | yes | no |
| Unexplained memory lapses | yes | no |
| Alcohol/Substance Abuse | yes | no |
| Frequent Body Complaints | yes | no |
| Eating Disorder | yes | no |
| Body Image Problems | yes | no |
| Repetitive Thoughts (e.g., Obsessions) | yes | no |
| Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) | yes | no |
| Homicidal Thoughts | yes | no |
| Suicide Attempt | yes | no |

**FAMILY MENTAL HEALTH HISTORY**:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

| Difficulty | | | Family Member |
|---|---|---|---|
| Depression | yes | no | |
| Bipolar Disorder | yes | no | |
| Anxiety Disorders | yes | no | |
| Panic Attacks | yes | no | |
| Schizophrenia | yes | no | |
| Alcohol/Substance Abuse | yes | no | |
| Eating Disorders | yes | no | |

Learning Disabilities yes no

Trauma History yes no

Suicide Attempts yes no

**Mother's health during pregnancy:**

Good Fair Poor

Any illness/complications during pregnancy (e.g., Rh negative, toxemia, diabetes)

Yes No

During pregnancy, was mother on medication? Yes No
If yes, what type?______________________________
During pregnancy, did mother smoke? Yes No
If yes, how much?______________________________
During pregnancy, did mother drink alcohol? Yes No
If yes, list quantity/frequency:__________________
During pregnancy, did mother use drugs? Yes No
If yes, what type?______________________________

Delivery:

Was baby premature? Yes No Length of pregnancy (months)___________

Type of Delivery: Vaginal Caesarean Birth Weight:____________________

Child's condition after birth?______________________________________________

**OTHER INFORMATION:**

What do you consider to be a strength your child has?

What are your goals for your child during therapy?

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# AGREEMENT FOR SERVICE / INFORMED CONSENT

***********Please take the time to read carefully**********

**Introduction**

This Agreement is intended to provide ______________________________________________ (herein "Patient") with important information regarding the practices, policies and procedures of LifeStyles Family Counseling and Consultation, Inc. and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

**Welcome.** We believe that you have taken a brave step towards making a healthier you. Therapy is a collaborative effort. Through dialogue, we can open up new perspectives and possibilities, allowing us to create meaningful change in your lives. We invite you to evaluate the usefulness of our therapy conversations. Therapy should be useful in creating movement toward your ideas and vision for your life and relationships.

**Meeting**: We normally conduct an evaluation that will last from 1 to 2essions. During this time, we can both (all) decide if we are the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually have one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment house is scheduled, you will be expected to pay for it unless you provide 24 hour advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].

**Appointments:** Appointments last 50-minutes. It is important to be on time as a late arrival cannot be made up by going overtime. If you need to cancel an appointment, we need to be notified at least **24-hours** in advance to prevent billing you for the session fee. If we are not notified within 24 hours of your appointment you will be required to pay for the missed session in full. If possible the appointment may be rescheduled within the week. Sessions longer than 50-minutes are charged for the additional time pro rate. Your agreed upon fee for each individual session will be paid prior to starting therapy session in the amount of
$______.

Fee Adjustment/Notes: ________________________________________________________

**Phone Calls and Treatment Progress Reports**: Phone calls and preparation of written reports lasting longer than five minutes will be eligible for a charge of $45.00 per every 15 minutes. Phone contact between sessions to make changes to appointment times will not be billed. Discussion of treatment material will be billed for every 15 minutes discussed. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than five minutes. Patient (or responsible party) is expected to pay for services at the time services are rendered.

**School/Home Visits:** In some cases a visit to your family's home and/or your child's school is necessary for appropriate assessment and treatment. All school and home visits will be billed at the regular hourly rate for time spent. In some instances, depending on traveling distance, there will also be a fee of $0.75 per mile for school and/or home visits.

**Payment for Service:** Clients are expected to pay for services at the time they are rendered. Cash and checks, are accepted at the start of your session time. To avoid wasting your valuable session time, please have your check made out and ready before your session. If a check is returned from the bank for insufficient funds, or if payment is stopped on a check or the account is closed, then that amount becomes due and payable, with an additional $35.00 charge per check.

**Insurance Payments:** Clients who carry insurance and choose to use insurance to cover professional services session will be charged to the insurance company. If you have decided to use insurance for payment of services you authorize for the release of relevant information to bill insurance company. Patient (or responsible party) is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Patient (or responsible party) is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

**Confidentiality:** In general, information disclosed within sessions is confidential and may not be revealed to anyone without your permission. All communication between us is both privileged and confidential. This means that we may not discuss your situation orally or in writing unless you request, in writing, the release of specific information. The law and professional ethics provides for certain exceptional situations in which the therapist is required to disclose information:
a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
c. If you introduce your emotional condition into a legal proceeding or if we are subpoenaed to give testimony.

The law also allows the therapist to break confidence when a client presents danger of violence to others or is likely to harm him or herself unless protective measures are taken. Disclosure may also be required in certain legal proceedings. Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, we, in the exercise of our professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we will make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

**Client's Rights & Responsibilities:** In addition to your right to confidentiality, you have the right to end your treatment at any time, for whatever reason, without any obligation except for fees already incurred. You have the right to question any aspect of your treatment. You have the right to expect that we maintain professional and ethical boundaries by not entering into a personal, financial, or professional relationship with you, which would compromise the therapeutic alliance. Therapy involves collaboration between the psychotherapist and the client. We will contribute my knowledge, skills and the willingness to do my best. The determination of success will ultimately depend on your commitment to your own personal growth and development.

**Termination of Therapy:** Therapist reserves the right to terminate therapy at his/ her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy,

Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

**In an Emergency:** If you have a life-threatening emergency, please dial 911.

**Contacting Us:** Our phone number is (909) 987-8400. You may leave a message for us on our confidential voicemail and we will attempt to return the call within 48 hours. If you call in the evening after 5pm, we may not receive your call until the next morning. In the event of a life-threatening emergency, you must call 911 and ask for assistance.

**Minors:** In the event a minor (under age 18) is the client, parent's/ legal guardian's signature is indication of permission to treat. In the event of families of divorce which ever parent hold legal custody of the child will have to authorize treatment of the minor. Copies of legal custody arrangements are required. Note on Legal Custody: If parents are separated, legally separated or divorced or the child or adolescent is otherwise under custodial care or guardianship you must submit with this informed consent the documentation giving you the legal right to pursue medical/psychological treatment for the child. We cannot work with your child without this document. If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of my concern. Before giving them any information, we will discuss the matter with you, if possible, and do my best to handle objections you may have with what we are prepared to discuss.

**E-mail, Internet, & Social Media:** Treatment material will not be discussed via email, text, or other electronic means. You are welcomed to email or text us, however, we will respond via phone. This will ensure that nothing is misinterpreted or compromised via e-mail or text. Please note that we do not accept requests to connect (friend, follow, etc.) on any social networking forum from current or former clients. This is to protect your privacy and to avoid blurring the boundaries of our therapeutic relationship. There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you. You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let us know, otherwise we may ignore you when we encounter each other in a public place. However, if you initiate greeting us, we will not ignore you and we will respond to greet you in return.

Note: Email and text are unsecure and not confidential meant of communication. If you choose to email please make note of this.

**Risks and Benefits of Therapy:** Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand one self, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

**Records and Record Keeping:** Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a **treatment summary** in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests. Therapist will maintain Patient's records for ten years following termination of therapy or ten years after Patient's twenty-first birthday. However, after these ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

**Psychotherapist-Patient Privilege:** The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

**Patient Litigation:** Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made herself available for such an appearance at the rate of $250 per hour.

Please feel free to ask any questions about the above information. Your signature below indicates that you have read and understand this agreement for services. I have read, understand and consent to the above policies of LifeStyles Family Counseling and Consultation, Inc.

Client's signature_________________________________ Date___________________

Client/Legal Guardian's signature_______________________ Date___________________

Client's name (please print) _____________________________ Date of Birth ____________

**Statement of the Therapist:** This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. We have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date & Initial of Therapist ________________________________________

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Cancellation Policy Agreement

I, ______________________________________, understand and agree that appointments must be canceled and/or rescheduled within 24 hours of initial scheduled therapy appointment. If appointments are not canceled/rescheduled within 24 hours of initial scheduled appointment I, _______________________________________, I am financially responsible for the fee of $_________ that is to be paid prior to commencement of next scheduled therapy session.

________________________________________ _____________
Client's Signature Date

________________________________________
Client's Name (Print)

________________________________________ _____________
Guardian Name (If Applicable) Date

________________________________________ _____________
Witness Signature Date

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# Acknowledgement of Receipt of *Notice of Privacy Practices*

LifeStyles Family Counseling & Consultation, Inc. *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you or your child,

______________________________________.
Printed name of client

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices*. We encourage you to read it in full.

If you have any questions about our *Notice of Privacy Practices*, please contact the LifeStyles Family Counseling & Consultation, at *(909) 987-8400*

I acknowledge that I have received the *Notice of Privacy Practices* of LifeStyles Family Counseling & Consultation.

______________________________ ____________________
Signature of Client or Legal Representative Relationship to Client

______________________________ ____________________
Print Name Date

______________________________ ____________________
Signature of Witness Date