# INFORMED CONSENT TO THERAPY

Therapy is a relationship that works because of clearly defined rights and responsibilities held by each person. This frame helps to create the safe environment required for participants to take risks and the support system required to empower their change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, the goal of which is your well-being. There are also certain limitations to those rights that you should be aware of.

## My Responsibilities to You as Your Therapist

### I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot, and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will only do so if the situation is an emergency. I will always act so as to protect your privacy, even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality. I use email only to answer questions and schedule services with perspective clients. I do not read or correspond via email with established clients because it is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs; they are, in theory, available to be read by the system administrator(s) of the internet service provider.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

4. Confidentiality does not apply in criminal or delinquency proceedings, court-appointed custody evaluations, client-initiated court cases, Board of Marriage and Family Therapy inquiries, supervision, consultation, grave disability, or court order. If I die or become incapacitated, you consent to having another mental health professional of my choosing to take possession of your file and to contact you.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couple's therapy with me. If you and your partner decide to have some individual sessions as part of couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish to be kept secret from your partner. I will remind you of this policy before beginning such individual sessions. If I am meeting with your minor child, I will need to balance your interest in the content and process of therapy with the need for your child to trust that what is said will be confidential. In general, I will report on your child's progress while limiting the amount of specific confidential information I give you.

II. Record-keeping

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

III. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

My Training and Approach to Therapy

My Masters is in Marriage and Family Therapy from St. Mary's University in Minneapolis, MN. I am a Licensed Marriage and Family Therapist (#2624), licensed to practice in the State of Minnesota. My approach to therapy is a mixture of several schools of thought, including structural, collaborative, narrative, cognitive behavioral therapy, and solution-focused. Most of all, I focus on building a trusting, caring, life-giving relationship with my clients.

I use a variety of techniques and ways of talking to work with you on the issues you wish to address. These techniques are likely to include dialogue, interpretation, cognitive reframing, EMDR, awareness exercises, self-monitoring experiments, art, journal-keeping, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. You have the

right to refuse anything that I suggest. On your part, therapy will require your active involvement, completion of homework assignments, and an active desire to reach your goals.

Therapy also has potential emotional risks. Since therapy often involves discussing unpleasant aspects of your life that you may not enjoy talking about with your friends or try to avoid thinking about altogether, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, or loneliness. Despite the possibility of negative emotional responses, psychotherapy has been shown to have significant benefits for people. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience or that therapy will work, but most people who take these risks find therapy to be very beneficial. Therapy is supposed to be helpful. If I do or say anything that makes you feel uncomfortable, please tell me about it. If you ever feel that I am not the right therapist for you, I can give you referrals to other professionals if you would like. I want you to have the best possible experience in therapy, even if it is not with me!

Meetings & Professional Fees

I conduct an initial 50 minute session at a cost of $180. Following the initial session is an evaluation period of 2 to 3 sessions, during which we can both decide if I am the best person to provide the services you need in order to meet your goals. I may suggest one 50-minute meeting per week at the onset of our work together, although some sessions may be scheduled more or less frequently based on your individual needs. We work together to determine how often and for what length of time we meet. The fee for these 50 minute sessions is $180. I charge on a prorated basis for additional services, such as longer sessions, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries for yourself or other professionals, and the time spent performing any other service you may request of me. Services may not be provided if there is an outstanding bill of $80 or more.

Cancelation Policy

Consistently attending therapy sessions is vital to your success. If you happen to be late, we still need to end on time so as not to run into the next person's session. Once an appointment hour is scheduled, you will be financially responsible if you were to cancel without a 24-hour advance notice, in which case a cancellation fee of $60.00 would be charged. If you were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the cancellation fee would be waived. The 24-hour cancelation policy is a compromise between changes in your schedule and my ability to give your appointment time to another person. It is important to note that insurance companies do not provide reimbursement for cancelled sessions charges. If you no-show for any reason, please call within three business days to confirm your next appointment. If after three business days I do not hear from you and/or you do respond to my attempts to reschedule, I will assume that you have decided to leave therapy and will make the space available to another individual. Referrals for other mental health professionals will always be furnished when requested.

Communication

I can be reached at (651) 621-0688 during normal business hours (9am – 5pm Weekdays). I am often unable to answer the phone as I am with other clients; however, messages will be checked and returned only during business hours. I do not provide 24 hour emergency coverage. If you have an emergency when I am not available please call Crisis Connection at (612) 379-6363, or 911. Crisis Connection is available 24 hours a day, 7 days a week. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance. Please let me know the numbers where you would like me to reach you at, and if I can leave a message at any of those numbers. I do not read or correspond via any social media with clients. I only use email to answer questions and schedule services with perspective clients. I am away from the office occasionally throughout the year during which I do not take or respond to phone calls or messages. I will return messages on the first business day after I return. I will tell you in advance of any anticipated lengthy absences. I do not have social relationships with current or former clients as that would confuse professional boundaries and could possibly hinder our progress in therapy. If we happen to meet in the community I will not acknowledge our relationship unless I am approached by you first.

Insurance

If you would like to use insurance, sessions must take place at the St. Louis Park location with the Parkdale Therapy Group. Information about Parkdale Therapy can be found at www.parkdaletherapy.com. I am in-network with Blue Cross Blue Shield, Health Partners, Preferred One, MA (MHCP), and Ucare.

Payment

I accept cash, checks, and most major credit cards. Returned checks will be subject to a $50 fee.

Court

Some clients, couples or families get involved in court proceedings, for example, divorce. The oppositional nature of legal proceedings is antithetical to my approach to therapy and limits my ability to be therapeutic during trying times in your life. As such, you agree not to bring me or our therapy work into your private legal proceedings. If court is unavoidable, and you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time away from the office even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $180 per hour for preparation and attendance at any legal proceeding. A $450 nonrefundable fee must be paid before any preparation for or attendance at any legal proceeding occurs. From this the hourly rate will be deducted for the first 2.5 hours of preparation and attendance.

Ending Therapy

You normally will be the one who decides when therapy will end, with three exceptions.

1. If we have contracted for a specific short-term length of therapy, we will finish when the contract ends.
2. If I am not, in my judgment, able to help you, because of the kind of problem you have or because my training and skills are, in my judgment, not appropriate, I will inform you of this and refer you to another therapist who may better meet your needs.

3. If you do violence to, threaten verbally or physically, or harass myself, my associates, or my family, I reserve the right to terminate therapy unilaterally and immediately. If therapy is terminated, I will offer you referrals to other sources of care.

Complaints

I hope and expect that therapy will be a very rewarding process for you, but if you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism and concerns seriously, and with care and respect. If you believe that I have behaved unethically you may contact the Board of Marriage and Family Therapy at (612) 617-2220.

Updated 9/1/14

## VERIFICATION OF RECEIPT OF PRIVACY PRACTICES AND CLIENTS BILL OF RIGHTS

My signature indicates that I have received a copy of Jake Voelker's Privacy Practices and Clients Bill of Rights.

_____

Print Client Name (and Guardian Name, if applicable)

_____

Client/Parent/Legal Guardian Signature Date

## VERIFICATION OF RECEIPT OF INFORMED CONSENT

I have read the informed consent (updated 9/1/14), had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the release of any information necessary to complete the billing process. I agree to pay the agreed upon fee for each session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Jacob M. Voelker MA, LMFT. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Mr. Voelker. By signing below I agree, or I agree on the behalf of my minor child, to this document.

_____

Print Client Name (and Guardian Name, if applicable)

_____

Client/Parent/Legal Guardian Signature Date

_____

Signature of Therapist/Witness Date

Date:

## CLIENT INFORMATION

Client's Name: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Last First MI

Date of Birth: _____ Age: _____ Social Security Number: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ May I contact you at home? ☐Yes ☐No Messages OK?* ☐Yes ☐No

Work Phone: _____ May I contact you at work? ☐Yes ☐No Messages OK?* ☐Yes ☐No

Cell Phone: _____ May I contact your cell? ☐Yes ☐No Messages OK?* ☐Yes ☐No

Who referred you: ☐Dr. ☐Hospital ☐Priest ☐Family ☐Friend ☐Other Name: _____
☐Self ☐Website found on (Please list) _____ May I acknowledge this referral? ☐Yes ☐No

Name of Employer: _____ Title/Position: _____

**Treatment of Minor Child**

Parent or Legal Guardian Name: _____ I give consent for treatment _____ (initial)

Child Name: _____Age/Grade: _____

## EMERGENCY INFORMATION

Name of local friend or relative (not living in same address):_____ Relationship to Client: _____

Home phone #: _____ Work/Cell phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jake Voelker, LLC to release any information required to process my claims.

_____ _____
*Client/Guardian Signature* *Date*

## CANCELLATIONS & FEES

**A 50 minute session is $80-$180 based on income. A 24-hour notice is required for all cancellations.** Otherwise, **$60 will be charged for the missed appointment.** This charge will be the client or guardian's responsibility.

**Fees:** **FMLA/Letters to physicians, employers, schools, other requests: $80.00/hour prorated**
**Reports/Court testimony (Includes all required time): $180.00/hour**

_____
**Client/Guardian Initials**

## AUTHORIZATION TO TREAT

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his license. I understand that my therapist will work with me to develop a treatment plan to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process, to carry out therapeutic homework assignments, and to follow through with any medical treatment as prescribed by my physician. I further agree to keep my or my children's scheduled appointments and understand that in failure to do so I incur a $60 cancelation fee, and that therapy may be terminated for non payment.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child(ren)'s treatment. I understand that I will be furnished a copy of the consent whenever I request it.

_____ _____
Client Signature/Responsible Payee Party Date

## CLIENT RIGHTS

**YOU HAVE THE RIGHT:**

1. To be treated with consideration and respect
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action.

**CONFIDENTIALITY OF INFORMATION:**

Laws insuring your right to privacy protects matters discussed with your supervised therapist. In most cases, your supervised therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is know or suspected (reporting is required by law).
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in/on the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

**SECURITY OF RECORDS:**

Your treatment of record related and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is strictly prohibited.

**RETENTION OF RECORDS:**

Treatment records are retained for a period of seven years following the termination of treatment for adults and until ages 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

**INFORMATION REGARDING PSYCHOTHERAPY:**

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a clients psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. I/We will attempt to provide treatment that is realistic in both areas.
4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; I/we will make these recommendations if they are appropriate, based upon our assessment.

_____
Client/Guardian Initials

## PURPOSE FOR VISIT

Reasons for seeking Therapy today?_____
_____
_____
_____
_____
_____

How and when did the issue arise? _____
_____
_____
_____

Any past attempted solutions? _____
_____

What goals do you hope to achieve in Therapy? (List in order of importance)

1._____
2._____
3._____
4._____
5._____

**Symptom Checklist (**Rate the symptoms according to current intensity)

**None**: Symptom not present
**Mild**: This symptom impacts quality of life, but not significant impairment of day-to-day functioning
**Moderate**: Significant impact on quality of life/functioning
**Severe**: Profound impact on quality life/functioning

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Depressed Mood | ☐ | ☐ | ☐ | ☐ |
| Anger | ☐ | ☐ | ☐ | ☐ |
| Sleep Disturbance | ☐ | ☐ | ☐ | ☐ |
| Fatigue/Low Energy | ☐ | ☐ | ☐ | ☐ |
| Poor Concentration | ☐ | ☐ | ☐ | ☐ |
| Feelings of Guilt | ☐ | ☐ | ☐ | ☐ |
| Elevated Mood | ☐ | ☐ | ☐ | ☐ |
| Social Withdrawal | ☐ | ☐ | ☐ | ☐ |
| Irritability | ☐ | ☐ | ☐ | ☐ |
| Sexual Problems | ☐ | ☐ | ☐ | ☐ |
| Phobias | ☐ | ☐ | ☐ | ☐ |
| Financial Problems | ☐ | ☐ | ☐ | ☐ |
| Hopelessness | ☐ | ☐ | ☐ | ☐ |
| Anorexia | ☐ | ☐ | ☐ | ☐ |
| Bingeing/Purging | ☐ | ☐ | ☐ | ☐ |

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Appetite | ☐ | ☐ | ☐ | ☐ |
| Hyperactivity | ☐ | ☐ | ☐ | ☐ |
| Hallucinations | ☐ | ☐ | ☐ | ☐ |
| Aggressive Behaviors | ☐ | ☐ | ☐ | ☐ |
| Mood Swings | ☐ | ☐ | ☐ | ☐ |
| Family Conflict | ☐ | ☐ | ☐ | ☐ |
| Weight Gain/Loss | ☐ | ☐ | ☐ | ☐ |
| Worthlessness | ☐ | ☐ | ☐ | ☐ |
| Panic Attacks | ☐ | ☐ | ☐ | ☐ |
| Social Isolation | ☐ | ☐ | ☐ | ☐ |
| Impulse Control | ☐ | ☐ | ☐ | ☐ |
| Personal Hygiene | ☐ | ☐ | ☐ | ☐ |
| Self-Inflicted Wounding | ☐ | ☐ | ☐ | ☐ |
| Difficulty Making Friends | ☐ | ☐ | ☐ | ☐ |
| Difficulty Keeping Friends | ☐ | ☐ | ☐ | ☐ |

## HEALTH HABITS AND PERSONAL SAFETY

**Exercise:** ☐ Sedentary (No Exercise)
☐ Mild Exercise (i.e., climb stairs, walk three blocks, golf
☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)
☐ Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes)

**Diet:** Are you dieting? ☐Yes ☐No If Yes, are you on a physician-prescribed diet? ☐Yes ☐No
Number of meals you eat a day? _____

**Caffeine:** ☐None ☐Coffee ☐Tea ☐Cola/Caffeinated Soda Number of cups/cans per day? _____

**Alcohol:** Do you drink alcohol? ☐Yes ☐No
**If Yes:** What kind? _____
How many drinks per week? _____
Are you concerned about how much you drink? ☐Yes ☐No
Have you considered stopping? ☐Yes ☐No
Have you ever experienced blackouts? ☐Yes ☐No
Are you prone to "binge" drinking? ☐Yes ☐No
Do you drive after drinking? ☐Yes ☐No

**Tobacco:** Do you use tobacco? ☐Yes ☐No
**If Yes:** ☐Cigarettes – pks/day_____ ☐Chew - #/day_____ ☐Pipe - #/day_____ ☐Cigars - #/day_____
☐# of years_____ ☐Or year quit_____

**Drugs:** Do you currently use recreational or street drugs? ☐Yes ☐No
**If Yes:** Please list: _____
Is there a history of problems with drugs or alcohol use in your family? ☐Yes ☐No

**Gambling:** Have you ever gambled in a casino, bet on races or sports, played cards for money or played the lottery? ☐Yes ☐No
**If Yes:** What kind? _____

**Sex:** Are you sexually active? ☐Yes ☐No
Do you have any concerns about your sexual activity, including
sexual dysfunction, sexual orientation, birth control or infertility? ☐Yes ☐No

**Personal Safety:** Do you have any legal concerns? ☐Yes ☐No
Do you have a history of any type of abuse? ☐Yes ☐No
**If Yes:** ☐Physical ☐Sexual ☐Emotional ☐Verbal ☐Neglect
Is there any type of abuse happening in your life now? ☐Yes ☐No

## Psychiatric History

Prior suicide attempts? ☐Yes ☐No
**If Yes:** When? _____
Circumstances that led to the attempt? _____
_____

Current or past suicidal thoughts? ☐Yes ☐No
**If Yes:** Please describe:_____
_____
_____

Have you had any prior therapy? ☐Yes ☐No

**If Yes:** When, and for how long?_____
What was the focus of previous treatment? Was there a DSM-IV diagnosis?_____
_____
Was it helpful? _____

Prior hospitalization for mental/emotional problems? ☐Yes ☐No

**If Yes:** Please describe (year/duration/reason for hospitalization) _____
_____
_____
_____

## MEDICAL HISTORY

Are you currently taking ***any*** prescription medication? ☐Yes ☐No

**If Yes:** Please provide the following details (to the best of your ability):

Medication Dose Method Physician

_____
_____
_____
_____

Are any of these medications for mental/emotional problems? ☐Yes ☐No

Please describe any significant history, surgeries, or hospitalizations: _____
_____
_____

Primary Care Physician: _____ Date of last physical exam/visit to Physician: _____
PCP's phone #: _____ Release of Information signed ☐

## SOCIAL HISTORY

Your current relationship status: ☐Single ☐Married/Partnered ☐Remarried ☐Separated ☐Widowed ☐Divorced (# of times_____)

| MEMBERS OF YOUR HOUSEHOLD | | | | |
|---|---|---|---|---|
| *Name* | *Age* | *Relationship* | *Any significant mental or physical health problems or chemical dependency (PRESENT)* | *Any significant mental or physical health problems or chemical dependency (PAST)* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| OTHER FAMILY MEMBERS WHO DO NOT LIVE WITH YOU | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Describe your current living situation: (dual residences, house, apartment, group home, etc.) | | | | |
| | | | | |

| | |
|---|---|
| Describe any current housing problems? Explain: | |
| How well do you relate with your partner or significant other? Explain: | |
| How well do you relate to your children? Explain: | |
| How well do you relate to your parents? Explain: | |
| How well do you relate to your siblings? Explain: | |

## EMPLOYMENT

| Are you currently employed? ☐Yes ☐No | | |
|---|---|---|
| *Occupation* | *Duration* | *Does your current position satisfy you?* |
| | | ☐Intellectually ☐Physically<br>☐Emotionally ☐Financially |

Do you feel you experienced any deterioration in your job/school performance due to the problem you are seeking counseling for? ☐Yes ☐No

**If Yes:** (Check all that apply): ☐Attendance ☐Conflicts with supervisors ☐Conflicts with co-workers
☐Erratic behaviors ☐Accidents/Safety violations

Rate your level of motivation: ☐Low ☐Medium ☐High

Do you or your family have financial concerns? ☐ Yes ☐No

## MILITARY SERVICE

| ☐Yes (*if yes, please fill in the table below*) ☐No | | | | |
|---|---|---|---|---|
| *Branch* | *Rank* | *Year* | *Duration* | *Outcome* |
| | | | | |

## EDUCATION

| Level | Field of Study | Grade Average | Year of Graduation |
|---|---|---|---|
| | | | |

## MAJOR CHANGES IN THE PAST YEAR

If Yes, please describe:

| | |
|---|---|
| Move/Relocation | ☐ Yes ☐No |
| Blended family issues | ☐ Yes ☐No |
| Death of a family member/ friend | ☐ Yes ☐No |
| Childbirth/Adoption | ☐ Yes ☐No |
| Job Changes | ☐ Yes ☐No |
| Relationship issues | ☐ Yes ☐No |
| Other: | ☐ Yes ☐No |

## LEGAL ISSUES

Have you had any legal issues? If yes, please explain: _____

_____

_____

## ABUSE HISTORY

Have you ever experienced any type of abuse as defined below? ☐Yes (*if yes, please describe*) ☐No

| *Type* | *Current* | *Past* | *Who abused you?* | *When/Duration* | *Outcome* |
|---|---|---|---|---|---|
| Physical | | | | | |
| Emotional | | | | | |
| Verbal | | | | | |
| Sexual | | | | | |

| | |
|---|---|
| Have you ever been a witness to domestic violence? | ☐Yes (*please describe*) ☐No |
| | |
| | |
| Have you ever been a victim of domestic violence? | ☐Yes (*please describe*) ☐No |
| | |
| | |
| Have you ever been physically, emotionally, verbally, or sexually abusive to others? | ☐Yes (*please describe*) ☐No |
| | |
| | |
| Are you concerned for anyone's safety in your family? | ☐Yes (*please describe*) ☐No |
| | |
| | |

## SUPPORT SYSTEMS

| | |
|---|---|
| Are there any *spiritual issues* that will have an effect on your treatment here? | ☐Yes (*please describe*) ☐No |
| | |
| | |
| Are there any *cultural issues* that will have an effect on your treatment here? | ☐Yes (*please describe*) ☐No |
| | |
| | |

| *Leisure/Social Activities* | | | | |
|---|---|---|---|---|
| Exercise | Recreational/Sports | Interests/Hobbies | Clubs | Friends (few/many?) |
| | | | | |
| | | | | |
| | | | | |