

1. Client Information

NAME (OR PARENT OF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_ PAGER \_\_\_\_\_

MAY WE CALL YOU AT  Home  Work  Cell MAY WE LEAVE A MESSAGE AT  Home  Work  Cell

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ ETHNICITY \_\_\_\_\_

EDUCATION (YRS) \_\_\_\_\_ DEGREE \_\_\_\_\_ AREA \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ HOW LONG? \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

NAME OF SPOUSE/PARTNER \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_ PAGER \_\_\_\_\_

MAY WE CALL YOU AT  Home  Work  Cell MAY WE LEAVE A MESSAGE AT  Home  Work  Cell

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ ETHNICITY \_\_\_\_\_

EDUCATION (YRS) \_\_\_\_\_ DEGREE \_\_\_\_\_ MAJOR \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ HOW LONG? \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

MARITAL STATUS  Single  Married  Separated  Divorced  Widowed  Domestic Partnership

IF MARRIED: AGE OF SPOUSE: \_\_\_\_\_ DATE OF MARRIAGE: \_\_\_\_\_

IF DIVORCED: DATE OF MARRIAGE TO EX-SPOUSE: \_\_\_\_\_ DATE OF DIVORCE: \_\_\_\_\_

IF DIVORCED MORE THAN ONCE: DATES OF PREVIOUS MARRIAGE & DIVORCE: \_\_\_\_\_

IF SEPARATED: DATE OF SEPARATION: \_\_\_\_\_

IF INVOLVED WITH A SIGNIFICANT OTHER: HIS/HER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

IF YOU LIVE TOGETHER: SINCE WHEN? \_\_\_\_\_ HOW LONG KNOWN? \_\_\_\_\_

WOULD YOU DESCRIBE YOUR INTIMATE RELATIONS AS SATISFACTORY OR UNSATISFACTORY? \_\_\_\_\_

NAMES OF CHILDREN	DOB	AGE	NAMES OF CHILDREN	DOB	AGE
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

Are your children living with you? \_\_\_\_\_ Other children living with you: Names, ages and relationship to you: \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

## 2. Medical Information

*This is a confidential record. Information contained in it will not be released to anyone unless authorized by you or required by law as explained in our informed consent to treatment. Please fill out completely.*

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_ Date of last Physical \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_

RELATION \_\_\_\_\_ PHONE 1 \_\_\_\_\_ PHONE 2 \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

Current Weight \_\_\_\_\_ One year ago \_\_\_\_\_ Maximum \_\_\_\_\_ When \_\_\_\_\_

Do you exercise Regularly? Y/N How? \_\_\_\_\_

Do you Sleep Well? Y/N Amount of Hours? \_\_\_\_\_ Easy to get to sleep? \_\_\_\_\_

What recreation do you enjoy? \_\_\_\_\_

The hardest time in your development was: Preschool  Grade School  Jr. High  High School  College  Now

<b>MEDICAL CONDITIONS</b>				
<b>Please check all that apply to you:</b>				
	Never	Seldom	Sometimes	Often
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias (fears)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over-eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER CONCERNS</b>				
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of Packs per week:				
Alcohol Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What do you drink? _____	Frequency (per week) _____		How Much? _____	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amount per week:				
Drugs (not medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What? _____	Frequency _____			

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

MEDICATION HISTORY				
	Never	Seldom	Sometimes	Often
Appetite Suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Relievers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives/Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List medications you are currently taking:

1.	4.
2.	5.
3.	6.

### 3. Additional Background Information

Are you currently in therapy elsewhere?  Yes  No Have you had previous therapy?  Yes  No

Problem	Date	Therapist & Location	Was Therapy Successful?

#### FAMILY HISTORY

Parents: Father's Age \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Age \_\_\_\_\_ Occupation \_\_\_\_\_

Did you grow up with both parents in the home?  Yes  No

If your parents divorced, what age were you? \_\_\_\_\_

Custody Arrangements \_\_\_\_\_

Step-father's Age \_\_\_\_\_ Step-mother's Age \_\_\_\_\_

Do you feel closest to your  Father  Mother  Step-Father  Step-mother  None  Other

Briefly describe your relationship with your father \_\_\_\_\_

With your mother \_\_\_\_\_

Siblings: Brother's first names & ages \_\_\_\_\_

Sisters' first names & ages \_\_\_\_\_

Other: Please explain if any member of your family has ever suffered from anything which could be described as an "emotional" or "psychological" problem: \_\_\_\_\_

Please mention any history of domestic violence, child abuse or sexual abuse in your family: \_\_\_\_\_

Please comment on any history of alcohol abuse or illegal drug use in your family: \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

List names and ages of family members involved in therapy:

1.	4.
2.	5.
3.	6.

In your own words, please state the nature of your main problem: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How would you rate how serious this problem feels to you?

Circle One:      1                      2                      3                      4                      5  
    Mildly Upsetting                      -                      Extremely Serious

Have you ever attempted suicide? \_\_\_\_\_ If Yes, when? \_\_\_\_\_  
 If Yes, method used \_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons? \_\_\_\_ If yes, when & how long? \_\_\_\_\_

What goal(s) would you like to accomplish through counseling? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Would you like spiritual/religious issues to be a part of your therapy?     Yes     No     Don't know

Note: It is important for the Client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

Church Affiliation (*if any*): \_\_\_\_\_  
 \_\_\_\_\_

Insurance information:

PROVIDER: \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

MAY WE CONTACT THIS PERSON TO THANK HIM/HER FOR THE REFERRAL? \_\_\_\_\_ (INITIALS) \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

#### 4. Informed Consent For Treatment

Please carefully read this document and sign, indicating that you understand and accept these conditions. It is important that you feel comfortable with your therapist and confident in his or her approach. Please contact me to discuss any condition that may be of concern to you.

**OFFICE POLICIES:** Your therapist can be reached for an appointment at (949) 709-8567. Your therapist will take at least two weeks of vacation per year. If you have a life threatening emergency dial 911 or go to your local hospital.

**APPOINTMENTS:** Your appointment time is reserved for you. It is your responsibility to notify your therapist at least 24 hours in advance if you are unable to attend. Cancellations of appointments less than 24 hours in advance and “no shows” are subject to the full fee for the appointment time.

**TREATMENT PROCESS AGREEMENT:** Initially your therapist will gather information concerning your presenting problem. He or she will take a history of your presenting situation and once your problem is well defined, you and your therapist will collaborate to set goals. Throughout treatment you may be asked to do homework between sessions. Completing your homework will help you in reaching your set goals in a timely manner. Signing this document indicates that you are in acceptance with the therapists policies and procedures.

**POTENTIAL RISKS AND BENEFITS:** Therapy is helpful to most clients; however, there are no guarantees of success. Clients may experience strong emotions such as anxiety, frustration, sadness and anger when dealing with troubling situations or unpleasant past events. Therapy can bring up memories or realizations that may be distressing and some clients may experience unanticipated personal dilemmas, worries or nightmares. In addition, trying to resolve issues with family members or other important people in your life can lead to discomfort and may lead to unexpected changes or results that were not originally intended. Like any professional or medical service, therapy may not succeed in producing successful results and for some people, symptoms or problems may become worse. In general, however, the discomfort experienced is part of the process of delving into uncomfortable feelings or problems so that you might emerge at a more satisfying and rewarding place in your life and relationships.

#### 5. Disclosure of Special Circumstances

SPECIAL CIRCUMSTANCES: Please share any special circumstances below: \_\_\_\_\_

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## 6. Terms Regarding Confidentiality & Privacy

**LIMITS ON CONFIDENTIALITY:** Confidentiality is the legal right to privacy for all Clients who receive therapy and is protected by both ethical practice and California law. I understand that there are some situations in which a therapist is legally obligated to take actions that he or she believes are necessary to attempt to protect the client or others from harm, and he or she may be required to reveal some information about a client's treatment.

- **CHILD ABUSE:** If a therapist has knowledge of or reasonably suspects that a child under the age of 18 has been the victim of child abuse or neglect, the law requires that the therapist file a report with the appropriate governmental agency. A therapist also may make the report if he or she reasonably suspects mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way. Once such a report is filed, the therapist may be required to provide additional information.
- **ELDER/DEPENDENT ADULT ABUSE:** If a therapist observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect, or reasonably suspects that abuse, the law requires that the therapist report to the appropriate governmental agency. Once a report is filed, the therapist may be required to provide additional information.
- **THREAT OF VIOLENCE TO OTHERS:** If a Client communicates a **serious threat of physical violence** against an identifiable victim, the therapist must take protective actions, including notifying the potential victim and contacting the police. The therapist may also seek hospitalization of the client or contact others who can assist in protecting the victim.
- **DANGER TO SELF:** If a therapist has a reasonable cause to believe that the client is in such mental condition as to be dangerous to himself or herself, the therapist may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection. *If such a situation arises, your therapist will limit disclosures to what is necessary.*

**REGARDING CHILDREN'S CONFIDENTIALITY:** If my minor child participates in therapy, I understand the importance of allowing him or her to develop a semi-confidential relationship with his or her therapist. As such, I understand that the most personal information that my child discusses with his or her therapist will not ordinarily be shared with me. Rather, my child's therapist will provide me with general summaries of my child's progress without private details. However, I understand that the therapist is committed to informing me about unusual or dangerous symptoms or behaviors (including violence, criminal activities, child abuse, self abuse, suicidality, or intentions to harm others, harm oneself, alcohol and substance use).

**PRIVACY:** The law protects the privacy of all communications between a Client and a therapist. This begins at the beginning of the consultation process. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law and or HIPAA. However, **there are some situations where your therapist is permitted or required to disclose information** without either your consent or authorization.

- **CONSULTATION:** Your therapist may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, he or she will make every effort to

avoid revealing identity of clients. The other professionals are legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record.

- **COLLECTION:** Disclosures required to collect overdue fees are discussed elsewhere in this Agreement. If you do not pay your fee, we are permitted to contact a collection agency.
- **COURT PROCEEDINGS:** If you are involved in a court proceeding and a request is made for information about the professional services provided you, and/or the records thereof, such information is protected by the therapist-Client privilege law, and no information will be provided without your (or your legally appointed representative's) written authorization, court order or compulsory process (subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required), has stated the valid legal grounds for obtaining PHI and your therapist does not have grounds for objecting under state law (or you have instructed him or her not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
- **GOVERNMENT AGENCIES:** If a government agency is requesting information for health oversight activities pursuant to their legal authority, your therapist may be required to give it to them.
- **LAWSUITS:** If a client files a complaint or lawsuit against his or her therapist, relevant information may be disclosed regarding that client in order for the therapist to defend himself or herself.
- **WORKER'S COMPENSATION:** If a client files a worker's compensation claim, the therapist must, upon request, disclose information relevant to the claimant's condition to the worker's compensation insurer.
- **COMMUNICATION METHOD:** Your therapist may contact you by cellular phone and E-mail. These technologies are not guaranteed of privacy. [May we contact you by cellular phone and email?](#) Y / N

**TERMINATION OF THERAPY:** Your therapist believes that how long you remain in therapy is a matter best left in your hands. Although your therapist will certainly provide counsel for you in this matter, you must make the ultimate decision about continuing care. We hope that a decision to end counseling will be discussed candidly and thoroughly with your therapist in advance of leaving.

## 7. Financial Responsibility

**PAYMENT & FEES:** You are expected to pay for services at the time they are rendered unless other arrangements have been made. Services are rendered and charged to the client, not to the insurance company. Upon request your therapist will provide you with a receipt for you to submit to your insurance company for reimbursement.

I agree to be responsible for the payment of \$ \_\_\_\_\_ per session (45 – 50 minutes) which is payable by cash or check at the time of the session. I understand that I may also incur charges for phone consultations and emails in 15 minute increments. There is a \$25 fee for returned checks. (Please refer to the fee schedule below for additional professional services and rates).

I understand that I am responsible for full payment, even though I may or may not be reimbursed by my insurance company. Checks are to be made payable to "Lisa Bergfeld".

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

PROFESSIONAL SERVICES & RATES:

Professional Services	Time	Rate
Initial Evaluation <i>(first appointment)</i>	70-75 minutes	\$160
Therapy Sessions	50 minutes	\$120
Extended Sessions	Each 15 minute increment	\$30
Late Cancellation or No Shows	Scheduled Session	Full Fee
Phone Consultation and E-mail	15 minute increment	\$30

I understand that services are provided by appointment only. Your scheduled appointment time is reserved for you alone. I agree to pay a Late Cancellation fee for any missed appointment that I do not call to cancel at least 24 hours in advance and by Friday at 5:00pm for Monday appointments except in the case of emergencies.

My signature below indicates that I have read this agreement in its entirety and agree to its terms. It further serves as an acknowledgement that I have received the HIPAA required notice contained herein and the Privacy Policy provided. I understand that I have the right to end therapy at any time with no obligation except to pay for completed services. I understand that upon request, I may have a photocopy of this agreement.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian if Client is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Financially Responsible Party

\_\_\_\_\_  
Date