

Dr. Kristen Platt
Marriage and Family Therapist

CLIENT INFORMATION SHEET

Client Name:	Age:	Date of Birth:
Home Address:		
City and Zip Code:		
Home Phone: ()	Cell Phone: ()	
Email:		
School:		
Grade:		
Name of Parent/Guardian:		
Address:		
Home Phone: ()	Business/Cell Phone: ()	
Referred By: May I contact this person to thank him/her for the referral?		
Previous Psychological Treatment or Counseling: Yes/No		
Therapist:	Phone: ()	
Address:		
Reason for seeking previous therapy and dates of treatment:		
Describe any current or recent (within 6 months) medical treatment, including medications:		
Physician:	Phone: ()	
Address:		
Date of Most Recent Physical Exam:		
Parent/Guardian Signature:	Date:	

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Dr. Platt offers psychotherapeutic services in accordance with California State law. California law requires the therapy relationship to be both professional and confidential. What is revealed in this setting is protected by legal, professional and ethical standards, such that, with a few important exceptions, all material is confidential and not released without your written consent. Ethically and legally, however, if there is a reasonable possibility of harming others or yourself, then as a licensed therapist, Dr. Platt is responsible to inform others, in order to protect them or yourself. Also, the State of California requires that if there is a reasonable possibility of child abuse or elder abuse, this must be reported to the proper protective service immediately.

GENERAL OFFICE PRACTICES

Phone Calls: I am available to return phone calls Monday through Friday between the hours of 9:00 a.m. and 6:00 p.m. If you need to make more than occasional calls that are other than scheduling related, I may encourage you to increase the amount of time we have together in the office. I have found this to be the best way to address your needs.

Cancellations: Appointments cancelled with less than 24 hours notice will be charged at the regular fee. If an emergency arises and you cannot keep your appointment, please call so that we can discuss the possibility of rescheduling. If we are unable to reschedule your appointment within the same week, you will be charged at the regular fee.

Fees: The fee for each for each 50 minute psychotherapy session is \$170.00. 75 minute sessions are \$255.00. Phone consultations of more than 15 minutes will be charged according to the length of the consultation. Payments for sessions are due at the conclusion of the appointment.

Client Litigation: Dr. Platt will not voluntarily participate in any litigation or custody dispute in which the client is a party. Dr. Platt has a policy of not communicating with attorneys retained by clients and will not write letters, reports or declarations to be used for legal purposes or provide records/ testimony unless compelled to do so. Should Dr. Platt be subpoenaed, or ordered by a court of law, to appear as a witness in any action involving client, client agrees to reimburse Dr. Platt for court appearance, including any time spent for preparation and travel, at the rate of \$200 per hour.

I consent to treatment and have read the above. I understand that the therapy relationship is a private and confidential one with the exceptions noted. I also understand and agree to the cancellation and payment policies above.

Parent/Guardian Signature: _____

CLIENT CONCERNS CHECKLIST

Concerns Involving Feelings or Behaviors

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tension | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Low energy | <input type="checkbox"/> Difficulty concentrating | |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Emptiness | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Shyness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Indecision | <input type="checkbox"/> Confusion | <input type="checkbox"/> Failure | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Jealousy | <input type="checkbox"/> Self-harm | <input type="checkbox"/> Mixed feelings | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Panic | <input type="checkbox"/> Isolation | <input type="checkbox"/> Stress | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Outbursts | <input type="checkbox"/> Lack of attention | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Lying | <input type="checkbox"/> Cheating | <input type="checkbox"/> Hostility |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Rages | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Arguing | <input type="checkbox"/> Obsessiveness |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Rape | <input type="checkbox"/> Assault | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Sexual harassment | <input type="checkbox"/> Trauma | <input type="checkbox"/> Conflicts with others | | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Difficulty with | <input type="checkbox"/> Eating, | <input type="checkbox"/> Sleeping, | <input type="checkbox"/> Waking | <input type="checkbox"/> Other _____ |

Abuse

- Neglect Physical abuse Sexual abuse Emotional abuse

Health Concerns

- Headaches Insomnia Pain Illness
 Chronic illness HIV/AIDS Pregnancy
 Abortion Other _____

Interpersonal, Educational & Employment Concerns

- Employment issues Peers Legal problems Recent move
 Learning problems Social problems Assertiveness Job loss
 Motivation Self-control Other _____

Relationship Concerns

- Communication Crisis Violence
 Break up Dating
 Unhappiness Sexual issues

Substance Use Concerns

- Alcohol: average amount used each week _____
 Drugs: type and amount used each week _____

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CONSENT TO TREAT MINOR

Minor Client Name _____ DOB _____

This agreement has been written to acquaint you, the minor's parent(s)/guardian(s), with some basic information about therapy for minor clients.

Participating in therapy can help clients learn new and helpful information about oneself and others including new and better ways of handling feelings and problems.

All information disclosed during therapy sessions remains confidential unless there is an applicable legal or ethical exception. Exceptions include suspected child abuse, elder or dependent adult abuse, threats of violence to an identifiable victim and self harm. When a minor is in individual therapy, parents have the right to ask for information about treatment, and the therapist, acting in the best interest of the client, has the right to limit the information disclosed.

I have read and understand the information above and I give my consent for the treatment of my child.

Signature of Parent/Guardian

Printed Name Date

Signature of Parent/Guardian

Printed Name Date