

Marriage & Family Matters / Counseling
NEW CLIENT INFORMATION

Revised as of 04/16/05

Today's Date _____	Therapist _____
Name _____	Birthday _____
Address _____	SS # _____
City _____	State _____ Zip _____
Home Phone _____	Email _____
Cell Phone _____	
Work Phone _____	Employer _____
___ Minor, ___ Single, ___ Married, ___ Separated, ___ Divorced, ___ Other _____	

All fees and charges are the responsibility of the client. All fees are due and payable at the time services are rendered. If appointments are not cancelled 24 hours in advance the client's on file credit card will be charged for the missed session fee. For your convenience you may sign your super bill at each session and MFM will handle charging your on file credit card for appointment fees.

On File Credit Card _____	___ MasterCard ___ Visa ___ American Express
Card Number _____	Expiration Date ____/____/____
Print Name _____	
On Card _____	Signature _____

Spouse's Name _____	Birthday _____
Children's Names _____	Age _____ Sex _____
_____	Age _____ Sex _____
_____	Age _____ Sex _____

Referred by _____

Reason for Seeking Counseling

Confidentiality

**Marriage & Family Matters
*Counseling***

CONSENT TO RECEIVE THERAPY

I (We) apply for and consent to counseling, psychotherapy, and diagnostic testing as recommended by and provided by my (our) primary therapist. I (We) agree to be responsible for the payment for services rendered at the time of service. I (We) also understand that any appointment not kept or cancelled 24 hours in advance will be charged to me (us) at the regular session rate.

I (We) accept that the sessions are confidential, and that there are limits to that confidentiality whereby the therapist would be required by law to protect the client or others (threats of suicide, abuse of minors or elders, or reports of plans to injure others).

My (Our) primary therapist is _____

My (Our) primary therapist is supervised by _____

I (We) consent and authorize the release of information between my (our) primary therapist and the therapists participating in the weekly supervision sessions.

Client(s) Signature(s) _____

Signature of Parent or Guardian _____ Date _____

Marriage & Family Matters
Counseling
Symptom Check List

Check any of the following symptoms that you experience:

- Trembling
- Twitching
- Feeling shaky

- Muscle tension
- Muscle aches
- Muscle soreness

- Restlessness

- Easy fatigability

- Shortness of breath
- Smothering sensations

- Heart palpitations
- Accelerated heart rate

- Sweating
- Cold, clammy hands

- Dry mouth

- Dizziness
- Lightheadedness

- Nausea
- Diarrhea
- Abdominal distress

- Flushes (hot flashes)
- Chills

- Frequent urination

- Trouble swallowing

- Feeling keyed up or on edge

- Startle response

- Difficulty Concentrating
- Mind goes blank

- Trouble falling asleep
- Trouble staying asleep

- Irritability

- Depressed mood
- Depressed most of the day
- Depressed more days than not
- Other people tell me I'm depressed

How long have you felt this way?

- Poor Appetite
- Overeating

- Insomnia
 - Sleep too much
- How many hours per day?

- Low energy
- Fatigue

- Low self esteem

- Poor concentration
- Difficulty making decisions

- Feelings of hopelessness

Name

Date

Marriage & Family Matters / Counseling
26451 Crown Valley Parkway, #201
Mission Viejo, CA 92691

1-800-449-9330
www.MFMCounseling.com