

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

Flashes (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

Date of last Doctor's visit _____

Name

Date

Marriage & Family Matters / Counseling
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www.MFMCounseling.com