KAREN BLANDEN, M.A.

LICENSED MENTAL HEALTH COUNSELOR—LICENSED MARRIAGE & FAMILY THERAPIST

C O N F I D E N T I A L C L I E N T Q U E S T I O N N A I R E

Name **Social Security #** **Initial Session Date**

Address **City** **State** **Zip**

Phone: Home (___)_____ OK to call? Y N Work (___)_____ OK to call? Y N

Cell (___)_____ OK to call? Y N E-mail _____ OK to use? Y N

Relationship status _____Years_____ Education_____

Employer/Occupation _____Years_____

Birth place_____Birthdate_____Age_____

Religious orientation (if any) _____ Currently active? _____

Have you received counseling services in the past? If so, please list when and purpose:

_____

_____

Please list any health problems you have now_____

_____

Please list all medications (prescribed or over-the-counter) which you take:

_____

Have you ever been hospitalized for mental health reasons? YES NO When: _____

Family & significant others: ***Name*** ***Age*** **Moth-**

er_____

Father_____

Still married to each other? _____ Your age when they split up? _____

Spouse/Partner (name & age):_____

Sisters & Brothers (first name & age): _____

_____

_____

Children (first name & age): _____

_____

Have you been married previously? _____ How long were you married ? _____

Why did relationship end? _____

Please circle any of the following which are currently problems for you:

Depression	**Fears**	**Sleeping**
Stress	**Sexual problems**	**Suicidal thoughts**
Self-esteem	**Panic**	**Guilt**
Communicating	**Alcohol/drug use**	**Eating problems**
Anger	**Terminal illness**	**Disturbing Thoughts**
Anxiety	**Memory/concentration**	**Perfectionism**
Fearing failure	**Making decisions**	**Death of loved one**
Health	**Relationship problems**	**Being gay/lesbian**
Obsession/Compulsion	**Legal matters**	**Other _____**

Has any *biological* family member ever had a drinking or drug problem, depression, nervous breakdown, mental disorder, or attempted suicide? Please describe:

_____

_____

What is your average *weekly* intake of alcoholic drinks? _____per week
Any recent increase?_____
At the time of your life when you were drinking the most, how much did you drink *weekly*?_____

List any other kinds of drugs you sometimes use, or have used in the past, legal or illegal:

_____

_____

What is your goal for counseling (what do you want to be different in your life)?

_____

_____

How did you find me? (Circle--internet, yellow pages, insurance website, personal referral, other)

If personal referral, may I thank this person? _____ Name_____

Who may I contact in case of emergency? _____Phone_____

By signing below, you agree to the following:
I understand that all services provided in this office are in compliance with the HIPPA regulations. I agree to pay for sessions at the time of service and not have any information communicated to my insurance company at all, unless agreed upon with the therapist.

I understand that any appointments that are not cancelled 24 hours prior to scheduled time are subject to a $35 charge and that FORGETTING MY APPOINTMENT IS NOT AN OPTION!

I understand the information contained in the following page and agree to participate in counseling treatment as outlined below.

Signature _____ Date _____

Parent/Guardian Signature_____Date _____

(if minor child under 18)

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I N F O R M A T I O N F O R C L I E N T S

My goal is to provide a range of cost-effective and solution-oriented counseling services to people like you who are seeking to improve the quality of their lives and relationships.

FEES. You are responsible for full payment at the time of your session. Cash, checks and MasterCard/Visa payments are accepted. I do not accept any insurance plans.

MESSAGES. I do not accept phone calls while in session. My voice mail is always available to you. I have no secretary and I make my own appointments. Nearly always, your call will be returned the same day.
I will limit our phone conversations to only necessary information and if you would like to discuss anything in more detail than 10 minutes, we can schedule a phone session, which will be billed as a counseling session.
If you are unable to attend a scheduled session, please CALL ME—DO NOT send an e-mail, as I sometimes an unable to check e-mail during the day. Also, due to confidentiality, I am unable to respond to your e-mails regarding counseling issues.

APPOINTMENTS. Counseling sessions are 45-50 minutes. Your appointments will end promptly at the time agreed, even if you arrive late, so I can prepare for my next client. Unlike other health professionals, I am only able to schedule ONE CLIENT per hour, therefore, once you schedule your appointment, no one else is able to take that time period. It is YOUR RESPONSIBILITY to make note of your appointment time. If you are UNABLE to attend your scheduled appointment, you must notify me at least 24 hours prior to your scheduled time. *You will be charged a $35 fee for appointments that are not cancelled 24 hours in advance unless you have experienced circumstances which both you and I would define as an emergency.* If you cancel two appointments in a row, you will be required to PRE-PAY before scheduling another appointment.

GOALS. At the outset, we will establish goals for your therapy. The success of your therapy requires an investment on your part. The more actively involved in counseling you are, the more effective counseling will be for you. We will review your goals periodically to assess our progress. Your signature above indicates your agreement to work toward these goals in your everyday life, and to use your weekly sessions for guidance, understanding, and training as to how best to achieve these goals.

CONFIDENTIALITY. Information shared with me is protected by professional ethics and state law and will not be disclosed to anyone without your written permission.
The only exceptions to confidentiality are:

1. **when there is danger of actual physical harm to yourself or someone else,**
2. **when physical or sexual abuse or neglect of a specific minor child or elderly person becomes known,**
3. **in legal cases, your clinical records or I may be subpoenaed by a judge, and**

CLIENTS WHO ARE DEPENDENTS. If you are requesting services as a guardian or parent, the same general practice applies with regard to confidentiality as outlined above. It is essential that your dependent have complete trust in me. However, as a parent or guardian, you have the right and responsibility to question and understand the nature of therapeutic activities and the progress of your dependent. I must use clinical discretion as to what is appropriate disclosure. In general, specific information will only be released with the dependent's consent, but I will discuss progress and your participation in treatment.