

PLEASE NOTE: If you are coming to see me for couples counseling, each of you must independently complete and sign their own copy of this form.

Name: _____ Birthdate: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact: _____ Cell: _____ Home: _____

Briefly describe your reason for coming to see me: _____

How did you hear about me? _____

What is your religious affiliation? _____ None

Education/Degrees: _____

Occupation: _____ How Long? _____

Place of Employment: _____ How Long? _____

If not employed, how long has it been since you worked? _____

What kind of job did you have? _____

What caused you to stop working? _____

Relationship Status: Single Married Divorced Separated Widowed Living Together

Current and Past Significant Relationships

To Whom Length of Relationship Ending Date of Relationship Children together

Briefly describe your current relationship: _____

Age of current spouse/partner: _____ Religion: _____

Education/degrees? _____ Occupation: _____

Is he/she currently employed? Yes No How Long? _____

Has your partner had previous significant relationships? Yes No Number of times: _____

How long since his/her last one? _____

Number of children from previous relationship: _____ Ages of children: _____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs?	How do you get along?

Extended Family: Parents, Siblings, And Others Close To You

Name	Relationship	Age	Occupation	Challenges: i.e. Alcohol, History Mental Illness

How was it to grow up in your family? _____

Medical Information

When were you last examined by a physician? _____ Name of Doctor: _____

List any health problems for which you currently receive treatment: _____

List any past health problems including accidents: _____

List any medications you currently take: _____

Women only:

How many pregnancies have you had? _____ Are you pregnant now? Yes No

Any miscarriages or abortions? Yes No _____ How many?

Men and women:

Are you sexually active? Yes No Beginning at what age? _____

Do you use birth control methods? Yes No If yes, what? _____

Have you ever had concern about eating habits? Yes No

Psychological/Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? Yes No

If so, when and where? _____

Was it helpful? _____

Have you ever thought about suicide? Yes No If so, did you have a plan? Yes No

Have you ever attempted suicide? Yes No If so, how many times? _____

Alcohol/drug use history

Do you feel you have a drug or alcohol problem? Yes No

Have you ever had any previous treatment for drug / alcohol abuse? Yes No

If so, when and where? _____

List all drugs, including alcohol, that you currently use, or have used in the last year (indicate frequency and amount): _____

Legal

Please list and describe any arrests or legal problems (including driving violations): _____

Jeri L Kramer, Psy.D. 602-690-7763

Website: www.jerikramer.com Email: jeri@jerikramer.com

Circle any problem that pertains to you at the present:

- | | | | |
|--------------|---------------------|-------------------|--------------|
| Anger | Education | Sexual Problems | Work |
| Drug Use | Loneliness | Bowel Troubles | Relationship |
| Fatigue | Ambition | Stomach Problems | Divorce |
| Finances | My Appearance | Suicidal Thoughts | Future |
| Friends | Concentration | Nightmares | Temper |
| My thoughts | Parenthood | Health Problems | Age |
| Nervousness | Relaxation | Making Decisions | Stress |
| Self-esteem | Sexual Orientation | Physical Abuse | Anxiety |
| Separation | Energy | Inferiority | Appetite |
| Sexual Abuse | Children | Career Choices | Weight |
| Shyness | Legal Matters | Self Control | Memory |
| Sleep | Under / Over-eating | Alcohol Use | Overeating |
| Unhappiness | Depression | Headaches | Fears |
- Other: _____

Circle everything that has happened to you in the past three years:

- | | | |
|--|-------------------------------------|--------------------------------|
| Death of a spouse/partner | Relationship Problems | Changes in relationship status |
| Death of another family member | Family Problems (Children, in-laws) | Loss of Job |
| Major illness or injury--yourself | Financial Problems | Move to another city or state |
| Major illness or injury--family member | Legal Problems | Other: _____ |

Please list any additional information that you feel may be helpful for me to know about you:

Office Policy and Financial Responsibility Statement

I UNDERSTAND THAT:

- Therapy sessions are **50 minutes** in length and are billed at **\$145.00 per session**. Extended sessions are billed proportionately. Payment of cash, check or credit card is due at each visit.
- Sessions of late arrivals will end on time and be billed the full fee.
- The rate of \$145.00 will also apply to time spent on providing special services, such as telephone sessions, phone calls, case consultations, and time spent discussing treatment with other authorized professionals.
- Jeri Kramer does not communicate with clients via text messages or social media platforms. Communication outside of therapy sessions is best done via her encrypted email account or phone.
- With the exception of Mayo Clinic Health Solutions, Jeri Kramer does not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I may receive a "super-bill" as a receipt to submit to a third party payer.
- **I must give 24-hour notice of appointment cancellation or I will be billed in full. MONDAY appointments must be cancelled by Friday at 5:00pm.**

initial _____

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named. I have read the above office policy regarding length of sessions, late arrivals, charges, missed appointments, etc. **I understand and agree to the stated terms.**

Signature of Client (or Parent of Minor child)

Date

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Limitation on Confidentiality when Providing Therapy to Couples

There are slightly different expectations and limits about confidentiality in couples therapy than there are in individual therapy. When I agree to treat a couple I consider that couple to be the patient. For instance, if there is a request for the treatment records of the couple, I will need the authorization of both members before I release confidential information. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the couple, not just an individual.

During the course of my work with a couple I often see each individual alone for one or more sessions. These sessions are a part of the work that I am doing with the couple, unless otherwise indicated. If you are involved in one or more of these sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple, I would also seek the authorization of the other individual before releasing confidential information to a third party.

Regarding sharing the content of these individual sessions with the other member of the couple, I will not disclose specific information from individual sessions to the other party, but I will share my impressions and generalizations in the interest of promoting greater insight and understanding for each.

By signing below, I acknowledge that I have read this policy understand it, that I have had an opportunity to discuss its contents with Jeri L. Kramer, PsyD, LPC and that I enter couple's therapy in agreement with this policy.

Signature: _____

Date: _____

Consent for Evaluation and Treatment

Your signature below indicates that you have received a copy of the INFORMED CONSENT from my website (www.jerikramer.com), and that you agree to abide by these terms during our professional relationship.

Name of client

Signature of client (or guardian if client is a minor)

Date