

**PLEASE NOTE: If you are coming to see me for couples counseling, each of you must independently complete and sign your 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
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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](http://www.jerikramer.com) Email: [jeri@jerikramer.com](mailto:jeri@jerikramer.com)

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**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:**

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# 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 Blue Cross Blue Shield, 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

## 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](http://www.jerikramer.com)), and that you agree to abide by these terms during our professional relationship.

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Name of client

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

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Date