Institute of Advanced Studies

CLIENT INFORMATION RECORD

(Please complete all information below and bring to your first session.)

Name ____M ( ) F ( ) Date____________________

Parent name(s) if minor____

Address____

Street City Zip

Home phone (____)_____________ Work phone (____)_____________Cell phone (____)_______________

Birth Date__________________________ Age ______ Email ____

Employer______________________________________Occupation_____________________________________

Spouse/Partner/Other Parent name__________________________ Cell phone (____)______________________

Address (if diff.) ____

Street City Zip

Birth Date__________________________ Age______ Email ____

Employer ____________________________________ Occupation_____________________________________

List full names of all persons currently living in your home, age, and relationship:

Name Relationship Age School attending (if minor)

____

____

____

____

Have you or a family member had counseling before? Y ( ) N ( ) Who did, with whom, and for what reason?

____

____

____

Physician name_________________________________Phone_____________________Last visit___________

All medical conditions, treatment(s), or medication(s) [mgs/dosages]___________________________________

____

____

____

Date of last physical, and outcome: ____

Client Information (contd)

Who referred you:____ May I thank them? Y [ ] N [ ]

Reason for seeking therapy:____

____

CONSENT TO THERAPY

Please read carefully:

I apply for and consent to counseling, psychotherapy and diagnostic testing as prescribed by the Therapist.
I agree that I am responsible for the payment of $150.00 per session, which is due and payable **at each session**.
(Any reduced fee agreed upon will be temporary, and renegotiated when circumstances change).
I understand that any appointment Cancelled or not kept with **less than 24 hours' notice**, will be charged to me.
I consent to communication with the referring professional should the therapist consider it to be in my best interest.
I understand that fees will be collected at the **beginning** of each session.
I understand that the therapist is obligated to report to authorities or take other protective measures should it become apparent there is danger to the client or others, or if there is reason to suspect **child, spousal, elder, or disabled adult abuse.**

I consent to (check one or both) ___text and ___email contact regarding my appointments. I understand that confidentiality cannot be assured with these forms of contact.

Signature of Client 1______________________________________ Date _______________
(or minor client)

Signature of Client 2______________________________________ Date _______________
(if any)

If client is a minor:

Signature of Parent / Guardian ________________________________ Date ________________

Signature of Parent / Guardian ________________________________ Date ________________