Ramona Taylor MA MFTI Marriage & Family Therapist Registered Intern
Inland Integrated Wellness Center.
817 West Grand Blvd. Corona, CA. 92882.
888-634-6999 x 16

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Legal Mandates Exceptions to Confidentiality

- When the therapist has knowledge or reasonable suspicion of physical abuse, sexual abuse, willful cruelty, or unjustified punishment, unlawful corporal punishment or injury or neglect, child abuse must be reported to Child Protective Services (CPS)
- When the therapist has knowledge or reasonable suspicion of physical abuse, abandonment, isolation, neglect, financial abuse or abduction of an elder or dependent adult the therapist must report abuse to Adult Protective Services.
- When the client communicates a "serious Threat of physical violence against reasonably identifiable victim or victims the therapist has a legal requirement to inform to law enforcement (and if appropriate, the intended victim).
- If a client is over 21 years old or older and tells the therapist he or she is having consensual sex with a minor under the age of 16 the therapist must make a mandated report to CPS
- If a client any age reports being involved in downloading, possessing, or transmitting child pornography the therapist is mandated to report to CPS

When a mandated report is made the therapist will inform the client of the need to file a report and help client to process their response.

Other exceptions:

- When a client discloses or implies a plan for suicide, the therapist has an ethical duty to take action to protect the client, which may include warning the authorities and/or the client's family members and emergency contact
- If the therapist is ordered by the court to provide confidential information, the therapist legally must comply. However, if appropriate, the therapist will do what she can within the law to advocate for limited release of information and to protect the client's confidentiality.
- When client uses third party payers, the client has waved confidentiality
- If the client commits an act of violence or theft against the therapist the therapist is no longer obligated to maintain confidentiality.

Signing below indicates that you have reviewed and understand confidentiality, the limits of confidentiality, and the policies regarding communicating confidential information with third parties, families, and other health care providers.
Remember: You can always ask the therapist questions about the types of information she would disclose. You can frame it in the following way: "if someone told you that they were doing _____ would you have to tell someone?"

Signature) _____ Date: _____

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Adult Therapy Intake Form

(To be completed by client)

Thank you for choosing me to assist you with your therapeutic needs. Please answer the following questions and sign the accompanying forms and bring them to our first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Employer _____ Occupation _____

Street Address: _____
City: _____ Zip Code: _____
Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Phone number of Emergency Contact _ (____)
_____relationship_____

Are you in a relationship? □ Yes □ No How long? _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married never divorced □ Separated
□ Divorced □ Widowed □ Remarried (after divorce) □Remarried after spouse's death)

How would you rate your relationship on the following scale? Put an **X** on the line:

Please list any children you have and their ages: _____

_____

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Who lives in your home at this time? _____

What significant life changes or stressful events (both positive and negative) have you experienced in the last 6 months? (i.e.: job changes, deaths, births, marriage/divorce, moving…)

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

How did you come to choose me as your therapist? _____

_____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If Yes, How many therapists have you seen, and for what were you seeking help at those times? _____

_____

2. What do you believe is *least and/or most* helpful in therapy? _____

_____

3. When was your last medical/physical exam _____?

_____

3. Are you currently taking any medications? Or are you being treated for any illness?

□ Yes □ No If yes, please describe_____ _____

_____

4. .As you see it, what is bothering you the most right now? _____

_____

5. When did you first notice this was bothering you? _____

6. Has anything like this happened before? If so, when? _____

_____

7. What do you do to feel better? _____

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PRESENTING PROBLEM

Please indicate any of these symptoms you have experienced the last 6 months:

□ Severe Sadness	□ Memory Problems	□ Suicidal Thoughts	□ Compulsive Behavior
□ Sleep Problems	□ Feelings of Hostility	□ Obsessive Thoughts	□ Weight Change
□ Acts of Violence	□ Social Isolation	□ Strange Thoughts	□Tension/Anxiety
□ Change in Appetite	□ Inability to Concentrate	□ Relationship Problems	□ Panic Attacks
□ Chronic Pain	□ Self-Injury	□ Hearing Voices	□ Hallucinations
□ Depression	□ Angry Outbursts	□ Sexual Problems	□ Restlessness
□ Lack of interest	□ Racing Thoughts	□ Nightmares	□ Blackouts

SOCIAL

Please indicate how well you are doing in the following areas:

	Not applicable	Cannot function	Serious Problems	Moderate Problems	Mild Problems	No Problems
How well you are doing on your job?	□	□	□	□	□	□
How well are you doing with your spouse or partner?	□	□	□	□	□	□
How well are you doing in family relationships?	□	□	□	□	□	□
How well are you doing in relationship with people outside your family?	□	□	□	□	□	□

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FAMILY MENTAL HEALTH HISTORY: Have you or anyone in your immediate family experienced any of the following?

	self	Family member	No experience
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Eating Disorders	☐	☐	☐
OCD	☐	☐	☐
Schizophrenia	☐	☐	☐
Suicide Attempt	☐	☐	☐
Suicide	☐	☐	☐
Drug or Alcohol Abuse	☐	☐	☐

Have you or any of your immediate family experienced any of the following?

	Self	Family Member	No experience
Domestic Violence	☐	☐	☐
Discrimination	☐	☐	☐
Disaster	☐	☐	☐
War	☐	☐	☐
Physical Abuse	☐	☐	☐
Psychological Abuse	☐	☐	☐
Sexual Abuse	☐	☐	☐
Victim of a violence	☐	☐	☐
Terminal Illness	☐	☐	☐
Other:_____ _____ _	☐	☐	☐

TRAUMA HISTORY

FAMILY OF ORIGIN INFORMATION

Describe how it was for you growing up (relationship with family, milestones school, health, outlook) _____

_____

Where have you lived? _____

_____

How would you describe your ethnicity? _____

_____

In your family of origin, who raised you? Who did you go to when you needed comfort?

_____

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Growing up, how many sisters and brothers did you have? _____brothers ____sisters

Where were you in the birth order? _____

Have lost contact with any members of your family (death, separation, etc.) □ No □ Yes

Who and how: _____

SOCIAL/ EDUCATIONAL/OCCUPATIONAL HISTORY

What occupations/positions have you held? _____

_____

What do you enjoy about the kind of work you have done? _____

_____

What is stressful about your current work? _____

_____

Are you or have you ever served in the military? ? □ No □ Yes

Have you ever been arrested? □ No □ Yes If *yes, please elaborate:* _____

_____

What level of schooling have you completed? _____

Where or who do you go to when you have troubles or when things going well? _____

_____

How would you describe yourself spirituality (religion, practices, faith, beliefs etc.) _____

_____

What hobbies or leisure activities do you enjoy or have you enjoyed in the past? _____

_____

_____

X_____ _____
Client Signature Today's Date

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

X_____ _____
Client Signature) Today's Date