



JANET WHITNEY, LMFT
Therapist - Coach - Author - Speaker

1151 Dove Street, Suite 225, Newport Beach, CA 92660

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949-677-9280

janetwhitneymft.com

LMFT# 18675

CLIENT INTAKE & CONSENT

Date: _____

Client Information:

Name: _____ **Name is auto-filled if signed online*

Gender identity is:

- Male
- Female
- Other _____

Date of Birth: _____

Phone: (Hm) _____ (Wk) _____ (C) _____

Address: _____

City: _____ State: _____ Zip: _____

May I have permission to mail to this address? Yes _____ No _____

Email: _____

Permission to use email? Yes _____ No _____

Reasons For Visit - Check all that apply:

- | | | | |
|---------------------------------------|--------------------------|---|--------------------------|
| • Addiction & Recovery | <input type="checkbox"/> | • Panic Attacks | <input type="checkbox"/> |
| • Anxiety | <input type="checkbox"/> | • Parent-Child Struggles | <input type="checkbox"/> |
| • Attention Problems | <input type="checkbox"/> | • Post-Traumatic Stress Disorder (PTSD) | <input type="checkbox"/> |
| • Depression | <input type="checkbox"/> | • Relationship Issues | <input type="checkbox"/> |
| • Fear/Phobia | <input type="checkbox"/> | • Sleep Issues | <input type="checkbox"/> |
| • Grief | <input type="checkbox"/> | • Stop Taking Medication | <input type="checkbox"/> |
| • Insomnia | <input type="checkbox"/> | • Stress | <input type="checkbox"/> |
| • Mid-life Crisis / Feeling Stuck | <input type="checkbox"/> | • Trauma | <input type="checkbox"/> |
| • Obsessive-compulsive Disorder (OCD) | <input type="checkbox"/> | | |

Other: Please describe _____



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How have you dealt with these issues and for how long? _____

What are your goals for treatment? _____

Have drugs or alcohol been a factor? _____

Home:

Marital Status? _____

Marriage History? _____

Others living at home? (please list ages and relationships) _____

Problems at Home? If YES, describe: _____

Work:

Employer: _____

Occupation: _____

How long at current job? _____

How long in current occupation? _____

Problems at Work? If YES, describe: _____



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Education:

Problems at School? If YES, describe: _____

Education: (list highest level of education attained) _____

Learning Disabilities? If YES, describe: _____

Daily Life:

How often do you exercise/week? _____

Duration and Type of your typical exercise? _____

History of gambling? If YES, describe: _____

History of reckless driving or car accidents? If YES, describe: _____

Sex / Intimacy: **Only answer if comfortable*

Sexually active? Yes _____ No _____

Libido (Sex Drive) _____

Substances:

How often do you drink alcohol? _____

How often do you smoke/vape cigarettes? _____

How often do you smoke/vape marijuana? _____

Sleep:

Average # hours of sleep _____

Typical bedtime _____ Typical wake-up time _____



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Legal Status:

Current legal situation(s) / problem(s)? If YES, describe: _____

Have you had legal problems in the *past*? If YES, describe: _____

Current Support Systems:

Family: If YES, describe: _____

Friends: If YES, describe: _____

Community: If YES, describe: _____

Sports/Hobbies/Music: If YES, describe: _____

Professional: If YES, describe: _____

Spiritual: If YES, describe: _____

Current Providers:

Current Psychiatrist:

Name _____

Phone _____

Reason _____

How Long Seeing _____

Current Therapist:

Name _____

Phone _____

Reason _____

How Long Seeing _____



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PCP:

Primary Care Physician: _____

Phone: _____

Do I have your permission to consult with your primary care physician to assure continuity of care? Yes____ No ____

Signature: _____

Health & Medication:

List any significant health problems: _____

List any medications you are taking and the dosage:



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Referral:

Who may we thank for referring you?

Name: _____

Phone: _____

Emergency Contact:

Emergency Contact: _____

Phone: _____

Relationship: _____

Financially Responsible Individual's Information:

Name: _____

Relationship to Client: _____

Phone: (if different from above): _____

Address: (if different from above):



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Informed Consent

Confidentiality Statement

All information shared in this treatment is confidential and may not be revealed to anyone without your consent, except in circumstances where disclosure is required by law. Circumstances in which disclosure is required by law include: reasonable suspicion of child, dependent or elder abuse or neglect; a client presenting a danger to self, to others and/or personal property of others; a client being gravely disabled. All other information cannot be shared unless you give written consent by signing a "Release of Information" form. You can revoke this permission at any time.

Confidentiality of Email Communication

It is very important to be aware that email and cell phone communication, including text messaging, can be relatively easily accessed by unauthorized people and can therefore compromise the privacy and confidentiality of such communication. Emails are particularly vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes or emails can easily be sent erroneously to the wrong address. Please notify your provider if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use email, text messaging, or faxes for emergencies.

Conjoint or Family Therapy

In couples or family therapy, or when different family members are seen individually for the same issue, confidentiality and privilege do not apply between the couple or among the family members. Your provider will use her clinical judgment when revealing such information. Your provider will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Consultation

Your provider consults regularly with other professionals regarding her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Emergencies

If there is an emergency during our work together, or in the future after termination which gives your provider cause to be concerned about your personal safety, the possibility of you injuring yourself or a reasonably identified third party or their property, or to insure you receive proper psychiatric care, your provider will do anything she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided as Emergency Contact on the Initial Interview Form.



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Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorney, nor anyone else acting on your behalf will call on your provider to testify in court or at any other proceeding, or request disclosure of psychotherapy records, unless specifically requested in writing by you.

Your Right to Review Records

Both the law and the standards of the profession require your provider to keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your provider determines that releasing such information might be harmful in any way. In such a case, your provider will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, your provider will release information to any agency/person you specify unless she assesses that releasing such information might be harmful in any way.

Financial Agreement

Your fee per visit is to be paid in full at the time of each session. We accept Zelle, Venmo, cash, check, cashier's check, Visa, MasterCard, and American Express. Fees are subject to change every six (6) months.

Initial here to accept Financial Agreement: _____

No-show and Cancellation Policy

Your visit has been reserved for you. You must cancel at least 48 hours prior to your scheduled appointment to avoid being charged the full fee.

Initial here to accept No-show and Cancellation Policy: _____

Telephone and Emergency Procedures

Your provider's cell phone number is provided on this form. This allows your provider to respond to her clients' needs in the most timely manner possible during business hours. However, in the event of a life-threatening emergency, please call 911.



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The Process of Therapy/Evaluation

Participation in therapy can result in a number of benefits to you, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your provider will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with certain situations. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your provider may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that can cause you to feel upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes another family member may view a decision that is positive for one family member quite negatively. Change can sometimes be easy and swift, but more often it can be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your provider is likely to draw on various psychological approaches depending, in part, on the problem that is being treated and her assessment of what will best benefit you. These approaches may include behavioral, cognitive-behavioral, psychodynamic, existential, family systems, developmental (adult, child, family) or psycho-educational.

Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, your provider will discuss with you her working understanding of the problem, treatment plan, therapeutic objectives and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your provider's expertise in employing them, or about the treatment plan, please ask. You also have the right to ask about other possible treatments for your condition and their risks and benefits. If you could benefit from any treatment that your provider does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Termination

You have the right to terminate therapy at any time. If your provider thinks that termination is premature, or in the event that your provider decides that she cannot be clinically beneficial to you, she will provide you with names of other qualified professionals whose services you might prefer.



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Statement of Understanding:

I have read and understand this information sheet and informed consent.

Client _____ Date _____

**Name is auto-filled if signed online*

Parent/Guardian (*if Minor*) _____ Date _____

**Name is auto-filled if signed online*

Provider _____ Date _____

I have received and reviewed a copy of the "HIPPA Notice of Privacy Practices".

Client _____ Date _____

**Name is auto-filled if signed online*