

Informed Consent for Treatment

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Qualifications—Master of Science, Counseling degree issued by California State University, Fresno with an emphasis in Marriage and Family Therapy. Licensed as a Marriage and Family Therapist with the California Board of Behavioral Sciences MFC 49402. National Counselor Certification. I am a member of the California Association of Marriage and Family Therapists (CAMFT). A copy of this code is available online at <http://www.camft.org>.

What NOT to Expect from Therapy—

1. **Quick-fix solutions:** Most problems don't develop in a few days or weeks and won't likely be resolved that quickly.
2. **Advice related to major life decisions:** I will help you think through the possibilities and consequences of decisions but my Code of Ethics does not allow me to advise you to make a specific decision.

What to Expect from Therapy—

1. **To learn:** Discover how the individual pieces of your life and your relationships fit together and interact. Learn how to identify thoughts, feelings, and behaviors to reduce distress and improve function and find better ways to manage self, relationships, and life. Learn healthier ways to communicate with yourself and others. Recent brain research helps us recognize the way the brain is programmed -- and can be reprogrammed-- by thoughts / "self-talk."
2. **To grow:** Skills training includes in-session instruction, modeling, role-play, use of guided imagery, and between-session interactive assignments. The work you do between sessions is important and often directs the focus of therapy. Some people think of therapy as a "Self 101" class.

Potential Benefits and Risks of Therapy—Most people report benefit from therapy. It is possible, however, that even positive changes in relationship patterns may produce unpredicted and/or possibly adverse responses from other people in the client's social system. It is possible that therapy may uncover issues that may not have surfaced prior to the onset of therapy. Focusing on sensitive issues can result in emotional pain and symptoms can get worse before they get better. Only you can decide if the benefits outweigh the risk. Of course, this topic is always open for discussion in session.

Confidentiality— What is shared in session is confidential with the following exceptions: 1) Suspected Child or Elder Abuse; 2) Danger to self or others; 3) A judge's court order for records. **Note:** This office does **not** provide records or write reports for legal, disability, or other requests.

No / Open Secrets Policy—Sometimes when treating couples or families, an individual will disclose a secret to me and ask that the other/s not be told. Generally, the holding of secrets from other members of the therapeutic relationship is not advised. Of course, there can be exceptions, so please bring these matters to my attention as soon as possible so that we can work through them.

Professional Fees, Cancellation Policies and After Hours and Emergencies

A 50 minute session is \$100 (Superbill for insurance billing provided) and a sliding scale may be used based on financial need and current practice capacity. Should Kaiser Permanente/Beacon Health authorization be denied full payment will become the responsibility of the client. Appointments are contracts to meet at an agreed-upon time and date. Because this time has been reserved, you may be charged full rate for all **appointments** not canceled at least **24 hours** in advance unless I am able to reschedule for another time during that week. This policy does not apply to unusual circumstances that are determined to be emergencies by both the client and the therapist.

I will generally check for messages at least twice a day. You may reach me by text message, leave a voice message (559/287-8867), or email (wendy@drbrox.com) and I will get back to you as soon as possible. Periodically I will be unavailable due to conferences or vacations and I will let you know in advance. If you are unable to reach me with an urgent/emergency mental health need please contact Community Behavioral Health (559) 449-8000 or go in person to 7171 North Cedar Avenue Fresno, CA where consultation is available 24 hours a day.

I have read and understand the above information.

Client Signature (Parent or guardian also signs if client is less than 18y/o)

Date

Intake Form Date: _____

*Please note: information you provide here is protected as confidential information.
Please provide what you consider relevant on this form and bring it to your first session.*

Client Name: _____ If Kaiser, Medical Record # _____

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Address: _____

Contact information: Which do you prefer? text / email / voicemail

Home/Cell/Other Phone: _____ OK to send a text message? Yes No

E-mail: _____ OK to email you? Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Marital Status:

Never Married Domestic Partnership Married Separated Divorced Widowed

Partner's Name (if applicable) _____

Who lives with you? Please list by name/age/relationship:

If previously married when and for how long:

Other significant relationships: Grandchildren/Friends/Pets:

Referred by (if any): _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

3. How many times per week do you generally exercise? _____

What types of exercise: _____

4. Please list any difficulties you experience with your appetite or eating patterns. _____

5. In the past month have you experienced overwhelming sadness, grief or depression?

No

Yes If yes, for approximately how long? _____

6. In the past month have you experienced anxiety, panic attacks or phobias?

No

Yes If yes, describe: _____

7. Are you currently experiencing any chronic pain? _____

8. Do you drink alcohol more than once a week? No Yes Amount: _____

9. How often do you engage in recreational drug use? Type _____

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

How would you describe your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
 None
If any please describe: _____

12. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
 No
 Yes, previous therapist/practitioner: _____

13. Are you currently taking any prescribed psychiatric medication?
 No
 Yes, please list: _____

14. List any previous psychiatric medications taken: _____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle

List Family Member (father, sister, etc.)

- Alcohol/Substance Abuse yes / no
- Anxiety yes / no
- Depression yes / no
- Domestic Violence yes / no
- Eating Disorders yes / no
- Obesity yes / no
- Obsessive and/or
 Compulsive Behavior yes / no
- Schizophrenia yes / no
- Suicide Attempts yes / no
- If yes, describe:

Abuse – yes / no
Physical/Emotional/Sexual
 If yes, describe:

Family of Origin:

Describe Mom: _____

Describe Dad: _____

Describe Their Marriage(s) _____

List siblings in birth order and describe: _____

Describe any significant childhood events: _____

ADDITIONAL INFORMATION:

1. Briefly describe your employment / education history:

Do you enjoy your work/schooling? Is there anything stressful about your current work/school?

2. Do you consider yourself to be spiritual or religious? No Yes
If yes, describe your faith or belief:

3. How would friends/family describe some of your strengths?

4. How would friends/family describe some of your weakness(es)?

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

For Couples:

1. What would your partner say are 2-3 things you do that contribute to the problems in the relationship? _____

2. What would your partner say are 2-3 things about you that strengthen the relationship?
