Tiffany Stadler, M.Ed, LPC Intern

Licensed Professional Counselor #R4888(Oregon)

Individual Client Information/Consent Form

This information will be used in your first sessions as a starting point for discussion. Please print, fill out, and bring with you to your first appointment. Please wait to sign and date the form. This will be done at the beginning of your first appointment. Thank you.

Legal Name:_____

Today's Date:_____

Child's Legal Name:_____

Home Address:_____

City, State, Zip Code:_____

Home Phone #:_____

Birthdate: _____ **Gender (circle): Male Female**

Email Address:_____

Does anyone else have access to your email?

Yes No

Relationship Status (circle):

Single Married Divorced Relationship Domestic Partnership Other

Living Arrangement (circle):

Alone w/Partner w/Partner & Kids w/Kids w/Family

Names and Ages of Children (if Applicable):

If Kids live at home part time or away from home, please describe arrangement:

What brings you to counseling at this time?

What do you hope to accomplish through counseling?

What have you already done to deal with the difficulties?

Have you had previous psychological counseling or psychiatric help?

Yes No

Circle all that apply:

- individual counseling

- Couples' counseling

- group counseling

- family counseling

If yes, when and where did you receive counseling and what were the issues?

List any medications and dosages you are currently taking:

Please list any significant health problems that your child has been, or is currently being, treated for:

What are your biggest strengths?

What do you do for fun, or to relax?

Do you exercise? **yes** **no**

If so how many times per week?

How long?

What type of exercise?

Describe your eating habits and diet?

Do you smoke cigarettes? **Yes** **No**

If Yes…
How many times per week? _____
How many packs per week? _____
How long have you smoked? _____

Do you consume alcoholic beverages? **Yes** **No**

If Yes…
How many per day? _____
How many per week? _____

Do you use non-prescribed (recreational) drugs? **Yes** **No**

If Yes…
What, and how often:

Interactions between client and therapist are confidential. Unless I have specific permission from you, I will not discuss the content of our sessions with any outside parties. There are four exceptions to confidentiality that Oregon State law requires mental health professionals to report.

1. **Incidences of child or elder abuse**
2. **Intent to commit suicide**
3. **Threats to do harm to self or another person**
4. **Court Order**

Additionally, in the even of a billing dispute, names dates and lengths will be disclosed to a collection agency and/or attorney.

The community in which we live can often feel small and the possibility that we may see one another outside of therapy is always present. Your confidentiality is first and foremost in such situations and therefore, I leave it up to you if you would like to verbally or non-verbally recognize our encounter. I will follow your lead in such situations as I understand that everyone has a different comfort level when it comes to the privacy of their therapy.

If I am unable to make an appointment, I will cancel the appointment by telephone with at least 24 hours notice. If I miss an appointment without giving 24 hours notice, I agree to pay the full session fee.

Fees are based on a sliding scale, but are typically $100 per hour per 50 minute session for individual child/adolescent, or families.

****All fees are due at the time of service and can be paid by check, cash, or credit card (Visa or MasterCard). I allow limited contact between sessions for informational purposes or emergencies. Any contact by either phone or email that is longer than 10 minutes will be billed at the rates above in half hour increments.**

At this time, we are not accepting insurance.
I have read and understand all aspects of this form and agree to the terms and conditions. By signing below, I am consenting to therapy and releasing Your Journey Counseling Services, LLC and Tiffany Stadler, M.Ed., LPC Intern from any and all liability resulting from therapy. I am the party responsible for payment of services and will pay in full at time of each therapy session. My signature below also confirms that I have received a copy of the "HIPPA Notice of Privacy Practices" and a "Professional Disclosure Statement" at the beginning of the first therapy session. I also understand that I can view, download, and print copies of both of these forms from the website of Your Journey Counseling Services, LLC: www.yourjourneycounselingservices.com under the 'Forms and Documents" tab.

Printed Legal Name:_____ **Date:**_____

Signature: _____ **Date:**_____

Please print a copy and bring to your first appointment.