Melissa Berschauer, M.A., LMFT
Licensed Marriage and Family Therapist -Lic. No. 98848
949-613-0899 | www.melissaberschauer.com

Client Intake Form

Please provide the following information and answer the questions below. Information that you provide here is protected as confidential information.

Name First, Middle Initial, Last			
Address			
City/State/Zip			
Birth Date		Age	
Gender	-	Marital Status	-
Telephone		May I leave a message?	☐ Yes ☐ No
E-mail			

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

Please list any children/age(s):

_____ _____

_____ _____

Your Employer: _____

Job Title: _____

Referred By: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Reason for Today's Appointment/Things You Would Like to Discuss

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Have you previously received any type of mental health services (counseling, psychiatric services, etc.)? ☐ Yes ☐ No

Are you currently taking any prescription medication? ☐ Yes ☐ No

If Yes, please list _____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If Yes, please list and provide dates _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Please list any specific health problems you are currently experiencing.

   _____

2. How would you rate your current sleeping habits?

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

   What types of exercise do you participate in?

   _____

4. Please list any difficulties you experience with your appetite or eating pattern:

   _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ Yes ☐ No

   If Yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ Yes ☐ No

   If Yes, when did you begin experiencing this? _____

7. How many alcoholic beverages do you drink per week? _____

8. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

9. Are you currently in a committed relationship? ☐ Yes ☐ No

If Yes, for how long? _____

If Yes, on a scale of 1-10, how would you rate your relationship (with 10 being "the best")? _____

10. What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY

Please check to identify and list if there is a family member with a history in any of the following.

	Family Member
☐ Alcohol/Substance Abuse	_____
☐ Anxiety	_____
☐ Depression	_____
☐ Domestic Violence	_____
☐ Eating Disorders	_____
☐ Obsessive Compulsive Behavior	_____
☐ Schizophrenia	_____
☐ Suicide or Suicide Attempt	_____

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Informed Consent for Treatment – In Person and/or Telemedicine

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

Professional Information:
I have a Master's of Arts degree in Clinical Psychology. I am licensed to practice in the State of California by the Board of Behavioral Sciences as a Marriage and Family Therapist (MFT). I am a member of the California Association of Marriage and Family Therapists (CAMFT). I am a Level II Gottman Trained Couples Therapist; certified Prepare/Enrich facilitator for couples counseling; grief and loss counseling certification; certified Anger Management Specialist Level II; advanced training in Cognitive Behavioral Therapy (CBT); as well as staying current through continuing education units. If you have any questions about my background or experience, please ask.

Fees:
The fee for service is: $ _____ per 50 minute session. Fees are payable at the time that services are rendered. If for some reason you find that you are unable to continue paying for your therapy, please inform me and I will help you consider any options that may be available to you at that time. Therapist charges an additional fee of $175 for any letters written on behalf of client. *Please note that therapist does not participate in any legal matters.

Appointment Scheduling and Cancellation Policies:
Sessions are typically scheduled weekly or bi-weekly (depending on need). Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, kindly notify me at least 24 hrs. in advance of your appointment. ***If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.***

*Please initial here to indicate your agreement with the fees, scheduling, and cancellation policies*_____

Confidentiality:
All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couples therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. I maintain a "no secrets" policy with couples therapy. This means that if you participate in couples therapy, I am permitted, at my discretion, to use information obtained in an individual session that you may have had with me, when working with other members of your family. However, individual therapy may be an option if a secret needs to be kept for safety reasons.

Exceptions to Confidentiality
Therapists are required to report instances of suspected child, elder abuse, and in some cases, threats of harm to yourself or another person.

Minors and Confidentiality:
Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. Consequently, I may discuss the treatment progress of a minor client with the parent or caretaker, but not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

Therapist Availability/Emergencies:
Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for me at any time on my confidential voicemail at (949) 613-0899. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have a medical or psychiatric emergency, please call 911.

About the Therapy Process:
It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. Remember, therapy is a service that you purchase, and if you are not happy with the services received, it is your responsibility to make that known so we can discuss any hindrances to your progress. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Participation in therapy does involve some risks, including the possible experience of intense feelings such as sadness, anger, fear, and guilt. Please remember that these experiences are natural and normal and an important part of the therapy process. Sometimes during therapy clients choose to make major life decisions, including decisions regarding family, relationships, employment, and lifestyles. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result.

Termination of Therapy:
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with myself. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Informed Consent for Telemental Health – When Applicable

I hereby consent to participate in telemental health as part of my therapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 949-613-0899 to discuss since we may have to reschedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Client's Printed Name Signature Date

_____

Therapist's Signature Date