

Please note that while you will be asked to talk about your answers in sessions, your partner will not be shown this form.

Name: _____ DOB: _____

Partner's Name _____

Address: _____

Phone: _____ May I leave a message? _____

May I text you appointment reminders? _____

Is it acceptable to email you? _____

email address: _____

Emergency Contact: _____

Relationship Status: (check all that apply)

- Married Living Together Divorced Partnered
 Separated Living apart Dating

Do you have children?

<u>Names</u>	<u>Age</u>	<u>Do they live with you?</u>
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1.

2.

3.

4.

5.

What kind of work do you do, and what kind of hours do you work?

What do you hope to accomplish through couples counseling?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

1. _____
2. _____
3. _____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

Have you received counseling before? _____

If yes, with whom?

Describe how it went for you:

Has either of you threatened to separate or divorce as a result of the current relationship problems?

Yes No If yes, who? Me Partner Both of us

If married, have either you or your partner consulted with a lawyer about divorce? Yes No If yes, who? Me Partner Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes No If yes, who? Me Partner Both of us

How enjoyable is/was your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are/were you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Anything else you would like to add?

SATISFACTION AND COMMITMENT

_____ % I am committed to staying in our relationship.

DISCLOSURE STATEMENT

AnneMarie Murdock, MA. 503 Van Trump St NW, Yelm WA 98597. Cell/text: (360) 481-3660;
e-mail: yelmprairiecounseling@gmail.com.

If an emergency arises and you cannot contact me, contact the Crisis Clinic at (360) 586-2800, OR call 911, OR go directly to St. Peter's Hospital Emergency Room.

Therapist's Credentials

Masters in Counseling and Psychology.

LMFTA: Licensed Marriage and Family Associate under the supervision of Leticia Nieto, PsyD.

Additional training in the areas of domestic violence and abuse, victim's advocacy, and intimacy techniques,

Therapist's Education: MA from St Martins University in Counseling Psychology. BA from Evergreen State College in Health and Human Development and Contemporary Social Issues.

Course of Treatment: Each couple's situation and needs are different. As we become more familiar with each other, we will be working on improving communication, and work specifically on issues that you bring with you. If problems of addiction become a primary issue, you will be referred for treatment on this issue with a chemical dependency professional, and attendance will determine whether we can continue to in our work as a couple. If you decide to terminate therapy, please let me know. I appreciate feedback, and would like to have the opportunity to give our time together some closure. You are always welcome back in the future, should you wish to return for more therapy.

Client's Cost Per Session: I do not accept insurance. I accept payment via credit card, ACH transfer, or cash at the beginning of session. If you would like a super bill, please let me know and I will email you one. Writing reports, lengthy phone calls, and running overtime is charged in fifteen minute increments at the hourly rate of \$100.

In the event of an unpaid bill, your name, address, phone numbers, social security number, date of birth, dates of service, and payment record may be disclosed to a collection agency or small claims court. In such incidents, I would, of course, attempt to notify you before taking such action.

Missed appointments

I understand that things happen and we can't always make an appointment. Please know that I have scheduled this time for you, and if you cannot make it I expect to be notified 24 hours in advance. If you miss an appointment without 24 hour notice, I will have to charge you for the appointment if you have missed more than one.

Legal Statements and Issues: Washington State law requires Licensed Therapists to provide clients with certain information about their rights and responsibilities (see WAC 246-809-710). This subsection does not grant (clients) new rights and is not intended to supersede state or federal laws and regulations, or professional standards. You have the right to refuse treatment and the right to choose a practitioner and

treatment modality that best suits your needs. If you wish to obtain a list of the acts of unprofessional conduct listed in the laws (RCWs), you may contact the Department of Health at:

Washington State Department of Health (360) 236-4030 101 Israel Road SE, Tumwater, WA 98501
Mailing address: PO BOX 47890, Olympia, WA 98504-7890
or visit: <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130.180>

Confidentiality and Releases of Information: I keep a record of the health care services that I provide to you. You may ask to see and copy that record. You may also ask me to correct that record. I have an ethical and moral responsibility to protect your confidentiality and I will not normally disclose your records to others. However, there are some limits to that protection. First, in some instances you may wish me to share information another person (attorney, minister, or another health-care provider). In such cases, you will be asked to sign a “release of information” form. Second, I may be required by law to disclose your confidentiality information. ***This would occur only in the following instances:***

- 1) If I have reason to believe your or someone else’s life and safety is threatened or endangered.
- 2) If there is evidence, or even suspicion, of physical or sexual abuse or neglect of a minor child or vulnerable adult (dependent, developmentally disabled, or incapacitated person). I must, by law, report all incidents of past or current abuse or neglect of children or vulnerable adults. I must also report serious threats against another person and serious suicide intentions.
- 3) As part of good professional practice, there are times when I consult with colleagues on various therapeutic issues. When I do, it is with considerable caution and I do not disclose any identifying information about you.
- 4) If a judge orders certain information disclosed in a legal proceeding. In legal proceedings when your psychological health is at issue (e.g. work related stress, divorce, custody battles, etc.) the attorney for the opposing side may have certain information subpoenaed. In that case, I would inform you of the subpoena and if you objected to my complying, you would have 14 days to seek a protection order to contest the subpoena. I cannot contest it for you and I may still be required to release the information.

Your signature verifies that you have read and understand the information in my disclosure statement and that I have offered you a copy.

Client 1 Signature _____ Date _____

Consent For Transmission Of Protected Health Information By NonSecure Means

I consent to allow AnneMarie Murdock to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: appointment, billing and resource information. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Client Signature _____ Date _____