Jennifer A. Meyer, LPC, LMFT, CST
50 S. Steele St, Suite 377, Denver, CO 80209
☎ 720.668.2453 ✉ jen@jenmeyertherapy.com

CLIENT INFORMATION Today's Date: _____/_____/_____

Name:
_____

Address:
_____

Street City State Zip Code

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Birthdate: _____ Age: _____

Relationship Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Cohabitating ☐ Other

Name of parent to contact if client is a child: _____ Cell Phone: _____

Email: _____

Other members involved in therapy:

Name	**Age**	**Relationship**
Cell phone	**Home phone**	**Work phone**

Name	**Age**	**Relationship**
Cell phone	**Home phone**	**Work phone**

Name	**Age**	**Relationship**
Cell phone	**Home phone**	**Work phone**

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Other important family members or members of household, not involved in therapy:

Name	**Age**	**Relationship**
Name	**Age**	**Relationship**
Name	**Age**	**Relationship**
Name	**Age**	**Relationship**

Have you participated in therapy or counseling in the past? Yes or No If yes, tell me about your experience of therapy (positive, negative, mixed, etc.):

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

Are you currently taking prescribed psychiatric medication? _____

If so, please list: _____

Has anyone in your family (immediate or extended) experienced difficulties with mental health (ex: depression, anxiety, bipolar, schizophrenia, substance abuse, etc.)?

Have you or members of your family been or are currently victims of abuse (physical, sexual, emotional)?_____

Have you or others in your family experienced other traumas (domestic violence, auto accident, war, etc.)? If so, please describe. _____

_____

_____

Are you or someone in your family currently suicidal or homicidal? _____

_____

Describe any compulsive/addictive behaviors in yourself or other family members (drugs, alcohol, gambling, spending, sex, etc.):

_____

_____

_____

Please describe your physical health at present (poor, unsatisfactory, good, very good, etc.): _____

_____

Please list any persistent physical symptoms or health concerns (ex: chronic pain, headaches, diabetes, poor sleep quality, etc.) and list any medications you are taking for this condition: _____

_____

_____

What is going well for you or in your family at this time? _____

_____

_____

Any significant losses in your life? Explain. _____

_____

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Please describe any resources/strengths that you have in your life (friends, family, job, spiritual beliefs, support, hobbies, etc.):

In your own words, what is the concern or problem that brings you into therapy today? _____

On a scale of 1 – 10 (1 = the "worst the problem could be" and 10 = "there is no problem"), circle how would you rate this problem today? **1 2 3 4 5 6 7 8 9 10**

What do you think may be the cause of this concern or problem? _____

What have you already tried to do to solve this concern? Anything work?

What would you like to gain from our work together (therapy goals):

On a scale of 1 – 10 (1 = no motivation and 10 = ready to do or try anything), how motivated are you to make changes that will improve your concern or problem? Circle: **1 2 3 4 5 6 7 8 9 10**

Who might you want to involve in therapy that is not here today? _____

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PLEASE READ THIS ENTIRE DOCUMENT AND OTHERS GIVEN TO YOU:

Thank you for sharing this personal information. I look forward to our work together. This information will be kept confidential within the limits described in the Mandatory Disclosure Statement document. Please read them thoroughly. Let me know if you feel uncomfortable signing any of them or if you have any questions.

FEES/PAYMENT:

I/We understand that the fee for myself and/or my family will be $325 for the initial consultation and $225 for each subsequent 50 minute session and that all payments are expected at the time services are rendered. Cash, checks and credit cards (Visa, MasterCard, Discover & American Express) are all accepted. All checks should be made payable to Jennifer Meyer.

By signing below, I/We accept responsibility for the payment for services at the time they are rendered. I/We also accept responsibility for **payment of sessions cancelled within 24 hours** of the scheduled appointment time.

Court testimony, depositions, and court preparation including travel time results in additional costs at the rate of **$350 per hour**.

INVOLVEMENT IN THERAPY – CONSISTENCY OF APPOINTMENTS:

You and your family have a right to terminate or quit therapy at any time. As long as you are in therapy, I strongly encourage you to keep all scheduled appointments. Life can be busy, and things get in the way. Therapy is an investment in your well-being and health. Making time for it can be a major step forward. Talk to me if you are having difficulty keeping appointments.

Therapy works best when you come to sessions with goals and ideas about what you want to address for the session. Please give me feedback about our work together. I am open to feedback. These are *your* sessions.

Sometimes in the course of therapy, individuals or family members may feel more pain, discomfort, or upset as issues are explored. Please let me know if that is happening to you or one of your family members.

Finally, it is important to come to your sessions sober. I cannot see you if you are under the influence of any substance. This rule is for your safety as well as mine. Plus, it allows you to gain as much as possible from your therapy.

LIMIT OF SERVICES AVAILABLE: I do not provide emergency and after-hours services. If you find yourself in a life-threatening situation, you agree to take the necessary steps to keep yourself safe, up to and including calling 911 or going to the emergency room (at your cost) if necessary. **I do not provide medications, psychiatric services, or psychological testing.**

I have read and understand these policies.

Client Name: _____ Client Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____