Life Balance Counseling Center

Richard Lui, MS & Associates
Licensed Marriage Family Child Counselor
Individual, couple, family and child counseling

FAMILY MEDICAL HISTORY

NAME:_____ DATE:_____

Seeking help with very real problems, from a professional, shows strength and wisdom. Our first step in getting to know each other is you completing this questionnaire. One of our aims in having you complete this questionnaire is to reduce the cost of therapy for our clients. Another purpose is to assure that we provide excellent services to our clients by having a foundation of complete information.

In completing this form, respond with the first thought that comes to your mind. Please answer questions briefly and if you need additional space you may use the back of this page.

Thank you for your cooperation.

Client Information and Policy Statement

Informed Consent

New Client: Welcome!

Thank you for choosing me as a psychotherapist. This is an opportunity to acquaint you with information relevant to psychotherapy confidentiality and office policies. I will be glad to answer any questions you have regarding any of these policies.

I. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with internal conflict in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strengths
2. Taking personal responsibility to make the changes necessary to attain your goals.
3. Identifying specific psychotherapy goals
4. Utilizing all available community, medical and self-help resources.

II. Appointments

Appointments are usually scheduled for 50 minutes. The practice's hours are by appointment only. Clients are generally seen weekly, more or less frequently as acuity dictated when you and I agree. In the event of an emergency and you are unable to reach your psychiatrist or therapist, you may call your primary care physician or the local emergency room, or the crisis hotline: (916) 368-3111

III. Confidentiality

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged" however, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities.
4. If I am ordered by the court to release information as part of a legal involvement.
5. When your insurance company is involved, e.g. in filing a claim, insurance audit, case review or appeal etc.
6. In natural disasters whereby protected records may be exposed.
7. As required by the Patriot Act.
8. When otherwise required by law.

You may be asked to sign a Release of Information form so that I may speak to the other healthcare professionals Or to family members

IV. Record Keeping

A clinical chart is maintained describing your counseling goals and progress, dates of fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those Situations as outlined in the Confidentiality section above.

Client Information and Office Policy Statement

V. Telephonic Consultations:

Sometimes having a face-to-face meeting is not possible. As such with enough advance notice I can and will facilitate a counseling session with you over the phone. The charge for this is the same as it would be if you came into the office. A full hour with me on the phone may not be necessary. You can also have a phone consultation with me that is prorated for the time we do spend on the phone based on your regular hourly rate.

VI. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about Your treatment, please inform me immediately and discuss the situation.

VII. Treatment Agreement:

It's important that we develop a treatment plan so both parties know what we are working on and with whom we are working. Usually our first three sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. A referral to an outside support group or treatment program may be suggested or required. For example, a referral to a substance abuse recovery group, a grief support group or a parenting group may be a necessary part of your treatment plan.

At times you will be asked to complete assignments outside of the therapy hour. These might include journaling, though and behavior tracking logs, practicing stress reduction techniques, practicing assertive communication skills or attending various support groups. The outside assignments are essential aspects of your treatment and failure to follow through may seriously impair my ability to help you. We will then have to reassess our treatment plan and decide if I can still be helpful to you. You are expected ton take an active role in therapy, which includes regular feedback to your therapist or counselor as to your progress. Treatment surveys will be provided for feedback.

VIII. The Decision to Terminate Therapy

The therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination includes, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy. The patient needs are outside of the therapist's scope of practice or competence or the patient is not making adequate progress in therapy. The patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the therapist will generally recommend that the patient participate in at least one, or more termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will attempt to ensure a smooth transition to another therapist by offering referrals to the patient.

Consent for Treatment:

I authorize and request Richard Lui MFT to carry out psychological exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, there are no guarantees about the outcome of the process. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my therapist and me.

_____ _____

Client Signature Date

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the child or dependent adult client and on his or her behalf legally authorize Richard Lui MFT to deliver mental health care services to him or her. I also understand that all policies described in this statement apply to the individual I represent.

Client Name.

_____

Signature of Parent/Legal Guardian/Legal Representative

_____

Relationship to Client Date

_____

Please state briefly what is troubling you now: _____

Have you ever been seen by a counselor/ therapist/ psychiatrist before?_____ List and give dates:

Why did you terminate? _____

Are you taking any medication now? List: _____

List all tranquilizers or antidepressants you have taken in the past:

Have you ever been hospitalized for psychiatric (emotional) reasons? _____
Explain:_____

Have you ever attempted suicide by accident or on purpose? If so when_____
And are you currently having suicidal thoughts? (If yes, please describe)_____
_____

Please describe use of alcoholic beverages. Please be specific. (History and current use):
_____
_____
On average how much alcohol do you drink a week_____
Do you currently use recreational drugs? Yes or no?_____
Have you ever had a DUI(driving under the influence)?_____
Have you ever been in a recovery rehab program? Yes or No?_____
If so, when?_____
Do you smoke?_____Extent of use:_____

Please indicate any current drug use and any drug history(use of any mind altering substance)
_____
_____

What do you want to accomplish in therapy? _____

In adulthood or childhood have you ever been a victim of physical abuse or sexual abuse? yes or no (e.g. hit, pushed, threats, or violence around you.)

If yes, please be specific (where and what kind) _____

Have you ever committed acts of physical or sexual abuse? yes or no (e.g. hit, pushed, threats, or violence around you)

If yes, please be specific (where and what kind) _____

Client Pre-Treatment Survey

Client Name: Date:

Please fill out this form. Your responses to the following questions will help me to provide the most effective services for you. Thank you for your cooperation.

Please rate how much you were affected by the following in the week before your first appointment

	Not at all	Mild	Moderate	Severe	Extreme
Thoughts or behaviors you Do over and over again					
Unusually high energy					
Feeling sad, blue or depressed					
Have you had thoughts wishing You were dead?					
Anxiety, "nerves" or tension					
Anger, hostility, or irritability					
Fear of things or places					
Belief that others want to hurt you					
Drinking too much or using drugs					
Unreal, strange or "bizarre" thoughts					
Have you felt like harming or killing yourself					

Please check the box which best describes how well you are doing on your job:

○	○	○	○	○	○
Not Working	Cannot function	Serious problem	Moderate problems	Mild problem	No problems

Please check the box that best describes how well you are doing in your marital/significant other relationship:

0☐ Not Applicable	1☐ 2☐ Cannot Function	3☐4☐ 5☐ Serious Problems	6☐ 7☐ Moderate Problems	8☐ Mild Problems	9☐ No Problems

Please check the box that best describes how well you are doing in your family relationships:

0☐ 1☐ Not Applicable	2☐ Cannot Function	3☐ 4☐ 5☐ Serious Problems	6☐ 7☐ Moderate Problems	8☐ Mild Problems	9☐ No Problem

Please check the box that best describes how well you are doing in relationships with people outside of your family:

0☐ 1☐ Not Applicable	2☐ Cannot Function	3☐ 4☐ 5☐ Serious Problems	6☐ 7☐ Moderate Problems	8☐ Mild Problems	9☐ No Problem

Please check the box that best describes your current physical health:

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Very Poor — Excellent

Please check the box that best describes your general happiness and well-being:

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Very Poor — Excellent

Please help me to evaluate the services by rating the following:

	Excellent	Very Good	Good	Fair	Poor
Promptness in answering your call:	O	O	O	O	O
Courtesy in handling your initial call:	O	O	O	O	O
Promptness of scheduling your appointment:	O	O	O	O	O
Ease of getting to my office:	O	O	O	O	O

Thank you for taking the time to complete this form.

Family History:

Mother's name, living/deceased, description of relationship with mother:

_____

_____

Father's name, living/deceased, description of relationship with father:

_____

_____

Names and ages of brothers and sisters (include half and step):

_____

_____

Please describe your childhood: _____

_____

Names and ages of your children:

_____

_____

Have you ever been a victim of a violent crime? Yes No Not Sure
If yes, please describe_____

_____

Other Information:

Please describe your spiritual identity/orientation:_____

_____

Please describe your interests/hobbies:_____

_____

Are you involved in legal action or a lawsuit which will affect your therapy? Yes No
If yes, please describe:_____

_____

Please feel free to include any other information that you believe is relevant to your counseling:_____

_____

_____

_____