

Introduction to Couples Counseling

Welcome to counseling. I look forward to meeting with you and getting started. People and their situations are often very complex – I need to understand as much of the context as I can in order to help with a solution. The following paperwork (though extensive) is designed to give me the context quickly. Please complete it and bring it to your initial appointment.

- The informed consent is our formal agreement to enter therapy – please be sure that you understand all the items, if not, ask me about them before you sign the form. Each adult needs to sign the consent form.
- Two disclosure forms follow pertaining to the sharing of information as well as email communications – these are self-explanatory.
- The “questionnaire” follows – only one person needs to complete it.
- With two people come two perspectives – each adult needs to complete the “reasons for seeking counseling” the “problems and other symptoms” and the “substance use checklist” paperwork – two copies of each form are included. Please complete these three sections without input from the other person.

I appreciate the opportunity to work with you. If you have any questions, feel free to call me directly, 760-494-4394,

Sincerely,

Jussi Light, M.A., LMFT

Informed Consent

(each adult should review, understand and sign below)

Your signature at the bottom of this page means that you understand and consent to the following policies and procedures:

Counseling is a collaborative process between therapist and patient(s) who work together on mutually agreed upon goals.

Participation is voluntary and is only effective when both patient(s) and therapist are actively striving for the patient's growth and change. Patients realize that participation in therapy can involve discussing issues that may be distressing – however, therapy is designed to help patients personally and in their relationships. When minors are involved, it may be necessary that parent(s)/guardian(s) participate in the counseling process with their child(ren) at the discretion of the therapist. Some problems may be best resolved with the participation of other family members or close relations.

Appointments are made in advance and start and end on time – a session lasts 50 minutes. If a patient is late, the session will still cost full price and end at the pre-arranged time. 24-hour advance notice is expected for cancellation or rescheduling. Any patient who fails to cancel, cancels at the “last minute,” or doesn't attend a regularly scheduled session *will be held responsible for full payment of the missed session*. Lateness, or cancellations made by the therapist will be rescheduled.

Emergencies: in the event of an emergency dial 911 or 800-479-3339. The therapist is available via telephone (760-494-4394 – sorry text messages are not received at this number) during business hours and will return emergency calls at his discretion. However, most phone calls will be returned during normal business hours on weekdays.

Payment is expected at the time of service and will be collected at the beginning of the session. Any check that is returned for insufficient funds will be assessed a \$25 fee.

Confidentiality is vital to trust - all sessions are confidential. This means the therapist will not discuss any aspect of the session or case with anyone outside of therapy without prior written consent of patient(s). It is important that all patients (especially children) have a confidential relationship with their therapist.

- Individuals attending therapy due to a **court mandate** or as consequence or condition of probation/parole may have to waive their rights to confidentiality and the therapist may be able to communicate to your probation/parole officer regarding your case.
- If you have **health insurance** that covers services, a minimum of information will need to be exchanged to insure reimbursement – however, you will be required to sign an authorization to release information.
- **Secrets** within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a patient divulges such a secret to the therapist, the therapist will use his discretion about revealing it. Generally, the therapist will ask the patient to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, he may refuse to continue working with the patient until the patient reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Limits of confidentiality: The following are exceptions to confidentiality and **MUST BE REPORTED** to the appropriate service and/or police. Please note – these reports are mandated by law and may be made without your consent or written permission.

1. If a patient (s) become a danger to himself/herself, steps will be taken to keep the person safe.
2. If the patient should become a danger to another identifiable person(s), the potential victim(s) will be warned and the police will be notified.
3. Any suspicion of child abuse (including physical, sexual, and/or emotional abuse as well as child neglect or endangerment) whether past or present, previously reported or not, will be reported.
4. Any suspicion of abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize Jussi light to leave voice messages at my home or with a family member or friend regarding appointments, billing issues, or other pertinent information regarding my Behavioral Health Care.

YES / NO (choose one) _____
Signature

I agreed to the above policies: _____
Signature Date

I agreed to the above policies: _____
Signature Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Jussi Light uses administrative staff to perform basic clerical functions that are ordinary and typical to run his therapy practice. Jussi Light's staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, email addresses, dates of birth, etc.) taken from client intake questionnaire.
2. Billing information (names, dates, charges, payments, payment methods, diagnostic codes, etc.).
3. Emergency contacts – in the unlikely event that Jussi Light becomes so ill or incapacitated that he is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, to cancel an appointment for Jussi when he is sick).

Staff will not have access to information about the content of counseling and therapy sessions. Staff will not have access to information about any communications (such as telephone, email, mail) that pertain to counseling and therapy matters.

I further understand that administrative staff will send me a monthly statement which acts as a receipt for payments received. It includes billing information (such as a diagnosis, billing codes, patient name, etc.) and is typically sent to me via email. Please check only one:

I will accept monthly statements by email. Please send them to the following email address:

please print clearly: _____

I do not want my monthly statement sent via email. Please give them to me/us directly at sessions.

By signing below, I understand and agree to the contents of this form.

Name: _____ date: _____

Name: _____ date: _____

Email communications with Jussi Light

Please read the following disclosures about communicating with Jussi Light using email:

1. Email is a non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you.
2. Many people still feel comfortable communicating via email because they have installed firewalls or other programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
3. Sent and received emails are stored on both Jussi Light's and your computer until deleted. Jussi Light may or may not delete such emails. Generally, mundane emails (questions about appointments, billing, etc) will be deleted while other emails may be kept for archival purposes. Any such saved emails will be kept in a password-protected account that only Jussi Light has access to.
4. In addition, whenever you send an email, it is stored in cyberspace and the authorities can access these emails under various circumstances – this is not a policy of Jussi Light, but is due to the nature in which email is transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider or email service.
5. Jussi Light will use email to respond to emails that you send him. If you request that your billing statement be emailed to you, he will do so.
6. As a rule, Jussi Light does not conduct therapy via email. However, he may use email to handle certain questions/issues that pertain to therapy and related content if they can be easily and simply handled over email. He may also choose not to use email to handle such matters. He will tell you if this is the case.

By signing below, I agree that I understand the disclosures listed above regarding communicating with Jussi Light using email. I also agree that if I send an email to him and request a response via email, that I am willing to accept the above-stated risks:

Each Adult must complete – if you do not want to correspond via email do not sign your name – instead, write “declined.”

Print Name: _____ Signature _____ Date: _____

Print Name: _____ Signature _____ Date: _____

Permission for Jussi light to initiate emails to you

Sign below if you give your permission for Jussi Light to initiate sending emails to you. Example: Jussi may be the first one to send an email to you, rather than just responding to your emails. Note: If you do not wish to have Jussi Light initiate emails to you, do not sign your name – instead, write “declined.”

Print Name: _____ Signature _____ Date: _____

Print your email clearly: _____

Print Name: _____ Signature _____ Date: _____

Print your email clearly: _____

Couples Questionnaire – one adult completes this form for the couple

Today's Date	Full Name of person completing this form	Current Age	Place of Birth

Home Phone	OK to leave message?	Work phone	OK to leave messages?	Cell Phone	OK to leave messages?

Full name of person NOT completing this form	Current Age	Place of Birth

Home Phone	OK to leave message?	Work phone	OK to leave messages?	Cell Phone	OK to leave messages?

Primary address of couple - Street Address	City	State/Zip

circle all that apply	how long since married/ cohabiting/separated?	ever been married before?	how many times?	partner ever been married before?	how many times?
married / cohabiting / living apart		yes / no		yes / no	

	yourself	your spouse / partner
race / ethnicity		
religion / denomination		
date of birth		
sexual orientation		
names & ages of children conceived with current spouse/ partner		
names & ages of children conceived with previous spouse(s)/ partner(s)		
highest level school completed		
current occupation		
current employer / school		
hours worked each week		
how long worked here?		
second jobs		
how long at this job?		
hours worked each week		
any problems at work / school?		
unemployed?		
why?		
how long unemployed?		

	yourself	your spouse / partner
last physical exam date		
results of exam?		
current physical problems		
any head injuries / seizures? when?		
any major illness past or present? what & when?		
any operations? what & when?		
any prior hospitalizations? for what & when?		
any family history of alcoholism?	Y / N who?	Y / N who?
any family history of depression?	Y / N who?	Y / N who?
any family history of mental illness?	Y / N who?	Y / N who?
list personal strengths		
list personal weaknesses		
list personal hobbies		

Please list **everyone else** who lives in the household at least two days / week - please list from oldest to youngest

Full name

Date of Birth

Age

School / occupation

Full name	Date of Birth	Age	School / occupation

Who can I call in case of an emergency?

Phone

City

Relationship to patient

Who can I call in case of an emergency?	Phone	City	Relationship to patient

Is anyone currently getting counseling? **Yes / No** Who? _____ why? _____

for how long? _____ With whom? _____ telephone _____

Is anyone currently under the care of a physician for physical problems? **Yes / No** who? _____

For what? _____ With whom? _____ telephone: _____

Name of patient's primary physician _____ Telephone _____

Has anyone ever been arrested and/or committed a crime? **Yes / No** who? _____

When _____ For what? _____

Outcome of situation _____

Couples Questionnaire Continued

Summary of previous counseling

Please begin with the FIRST therapist you ever had and move forward to the most recent therapist
if you need more room, use back side.

	name of therapist and degree (MD, PhD, MFT, etc.)	start & end dates - - how often did you meet? (weekly?)	reasons for seeking treatment -- reasons for stopping treatment	what type of therapy? was it helpful? did you have any negative reactions?
1				
2				
3				
4				
5				
6				
7				

THANK YOU FOR FILLING OUT ALL THESE FORMS!

Name _____ Reasons for seeking counseling

(each adult complete this form)

Name: _____ Date: _____

Why are you coming to counseling at this time? _____

Are you being pressured to come to counseling? By whom and why? _____

Have you been referred? **Yes / No** by whom? _____

May I have your permission to thank the person/agency who referred you? **Yes / No** _____
signature authorization

What problems are you wanting to address in counseling?: _____

How long have these problems existed? _____

What makes these problems worse? _____

What makes these problems improve? _____

Overall, how motivated are you to change these problems? **Circle one:** Very motivated-----not motivated
10 - 9 - 8 - 7 - 6 - 5 - 4 - 3 - 2 - 1

What do you expect from therapy? _____

Name _____ Reasons for seeking counseling

(each adult complete this form)

Name: _____ Date: _____

Why are you coming to counseling at this time? _____

Are you being pressured to come to counseling? By whom and why? _____

Have you been referred? **Yes / No** by whom? _____

May I have your permission to thank the person/agency who referred you? **Yes / No** _____

signature authorization

What problems are you wanting to address in counseling?: _____

How long have these problems existed? _____

What makes these problems worse? _____

What makes these problems improve? _____

Overall, how motivated are you to change these problems? **Circle one:**

Very motivated-----not motivated
10 - 9 - 8 - 7 - 6 - 5 - 4 - 3 - 2 - 1

What do you expect from therapy? _____

Problems and Other Symptoms

(each adult complete this form)

Name: _____ Date: _____

Please check any of the following which may apply to **anyone in the household** – this includes issues not relating to the reasons you are coming to counseling.

<input checked="" type="checkbox"/>	problem	who has problem?	<input checked="" type="checkbox"/>	problem	who has problem?
	alcohol use			inability to relax	
	angry outbursts			legal matters	
	anorexia or bulimia (past / present)			loneliness	
	anxiety			loss of interest in things	
	bad dreams			loss of sexual interest or desire	
	boredom			marriage problems	
	can't get motivated to do things they usually enjoy			memory problems	
	career choices			nervousness	
	crying easily			overeating	
	depression			parent - child conflict	
	difficulty concentrating			poor appetite	
	difficulty falling asleep or staying asleep			poor or decreased ambition	
	difficulty getting up in the morning			pornography use	
	difficulty making decisions			preoccupation with death	
	difficulty parenting			school problems	
	divorce			self-confidence	
	drug use			self-mutilation	
	easily annoyed or irritated			sexual problems	
	energy problems			shyness	
	extreme fear of places or events			stuttering	
	faintness or dizziness			suicidal attempts	
	fatigue			suicidal thoughts	
	feeling fearful			thoughts hard to get rid of	
	feeling inferior to others			trouble remembering things	
	feeling tense or nervous			uncontrollable outbursts of temper	
	financial problems			unhappiness	
	friendship problems			violent behavior	
	gambling			violent thoughts	
	guilt			work problems	
	impulsiveness			worrying about things	

Problems and Other Symptoms

(each adult complete this form)

Name: _____ Date: _____

Please check any of the following which may apply to **anyone in the household**. Please check issues even if they do not relate to the primary reasons you are coming to counseling.

<input checked="" type="checkbox"/>	problem	who has problem?	<input checked="" type="checkbox"/>	problem	who has problem?
	alcohol use			inability to relax	
	angry outbursts			legal matters	
	anorexia or bulimia (past / present)			loneliness	
	anxiety			loss of interest in things	
	bad dreams			loss of sexual interest or desire	
	boredom			marriage problems	
	can't get motivated to do things they usually enjoy			memory problems	
	career choices			nervousness	
	crying easily			overeating	
	depression			parent - child conflict	
	difficulty concentrating			poor appetite	
	difficulty falling asleep or staying asleep			poor or decreased ambition	
	difficulty getting up in the morning			pornography use	
	difficulty making decisions			preoccupation with death	
	difficulty parenting			school problems	
	divorce			self-confidence	
	drug use			self-mutilation	
	easily annoyed or irritated			sexual problems	
	energy problems			shyness	
	extreme fear of places or events			stuttering	
	faintness or dizziness			suicidal attempts	
	fatigue			suicidal thoughts	
	feeling fearful			thoughts hard to get rid of	
	feeling inferior to others			trouble remembering things	
	feeling tense or nervous			uncontrollable outbursts of temper	
	financial problems			unhappiness	
	friendship problems			violent behavior	
	gambling			violent thoughts	
	guilt			work problems	
	impulsiveness			worrying about things	

Substance use Checklist – Name _____

(Each Adult completes separate form)

I consume alcohol....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1time/ month
<input type="checkbox"/>	2-4 times / month
<input type="checkbox"/>	2-4 times / week
<input type="checkbox"/>	daily

When I drink, I usually drink....	
<input type="checkbox"/>	none
<input type="checkbox"/>	1-2 drinks or beers
<input type="checkbox"/>	2-3 drinks or beers
<input type="checkbox"/>	3-4 drinks or beers
<input type="checkbox"/>	5+ drinks or beers

I get drunk....	
<input type="checkbox"/>	never
<input type="checkbox"/>	1x/ month
<input type="checkbox"/>	1-4x/month
<input type="checkbox"/>	2-4x / week
<input type="checkbox"/>	daily

I've been drinking like this for the...	
<input type="checkbox"/>	last month
<input type="checkbox"/>	2-6 months
<input type="checkbox"/>	6-12 months
<input type="checkbox"/>	more than a year
<input type="checkbox"/>	more than 3 years

My drinking has resulted in one or more of the following...	
<input type="checkbox"/>	passing out
<input type="checkbox"/>	sleep disturbances
<input type="checkbox"/>	can't stop once I start
<input type="checkbox"/>	blackouts
<input type="checkbox"/>	relationship problems
<input type="checkbox"/>	binges
<input type="checkbox"/>	work/school problems
<input type="checkbox"/>	seizures
<input type="checkbox"/>	Assaults &/or arrests
<input type="checkbox"/>	physical withdrawal
<input type="checkbox"/>	legal problems
<input type="checkbox"/>	medical complications

The following apply to me (check all that apply)	
<input type="checkbox"/>	I rarely or never drink – not even socially
<input type="checkbox"/>	I'm an occasional/ social drinker
<input type="checkbox"/>	I'm not sure if I have a problem
<input type="checkbox"/>	I probably have a problem
<input type="checkbox"/>	I have a problem, and I want to stop
<input type="checkbox"/>	I have a problem, but I don't want to stop

I've tried to control my drinking with....	
<input type="checkbox"/>	Nothing!
<input type="checkbox"/>	I stopped on my own
<input type="checkbox"/>	I've attended AA / other 12-step program a few times
<input type="checkbox"/>	I've attended AA / other 12-step program a regularly
<input type="checkbox"/>	I attended day or outpatient treatment
<input type="checkbox"/>	I attended inpatient / residential treatment
<input type="checkbox"/>	I attended a community-based program (e.g., church program, etc.)
<input type="checkbox"/>	I was forced to attend treatment of some kind

I currently use / I once used / I only ever tried....				
	only tried	used regularly	age started	age stopped
none				
pot				
sedative				
stimulant				
cocaine				
meth				
inhalants				
Heroin/ opium				
prescription drugs				
LSD, mushrooms				
other				

The following apply to me (check all that apply)	
<input type="checkbox"/>	I don't gamble
<input type="checkbox"/>	I gamble occasionally
<input type="checkbox"/>	I like to gamble
<input type="checkbox"/>	Gambling has caused me problems
<input type="checkbox"/>	I have gambled until all my money was gone
<input type="checkbox"/>	I have gambled more than I planned to
<input type="checkbox"/>	I like to gamble to escape worry or trouble
<input type="checkbox"/>	I have borrowed money in order to gamble
<input type="checkbox"/>	At times I've felt remorse after gambling
<input type="checkbox"/>	I've lost time from work or school due to gambling

