

Form 1 **Client Registration**

This form helps us to get to know you and ensures that we can contact you as needed. Also, we aggregate and analyze the information collected on this form for all of our clients to better plan, fund, and evaluate our efforts. Your personal information is confidential and voluntary.

Form 2 Appointment Reminder Form

Council for Relationships can remind you of your next appointment with your clinician by texting, emailing, or calling you. The automated appointment reminder system is in accordance with all confidentiality laws, and in order to protect your privacy, the reminders will come from an email address or phone number that is not linked to the Council. If you would like to receive automated appointment reminders from the Council, please complete and sign this form.

Form 3 **Get More Information from the Council for Relationships**

If you are interested in receiving information from Council for Relationships on how to foster healthy relationships, let us know!

Form 4 **Consent to Treatment**

Please review Council for Relationships' policy regarding treatment, which outlines confidentiality, payment and cancellation policies. Please sign the Consent to Treatment Form. If you have any questions, please discuss them with your therapist.

If you were given a professional referral to Council for Relationships, we would like to send our appreciation. Please provide the referring professional's contact information.

Form 5 **Client Acknowledgement Form**

Council for Relationships adheres to HIPAA regulations regarding the privacy of your health information. Please sign the Client Acknowledgement Form to indicate your awareness of this policy. If you would like more information, please discuss with your therapist.

Form 6 **Areas of Concern**

In order to assist your therapist with understanding your concerns, please take a few minutes to complete this important form.

COUNCIL FOR RELATIONSHIPS - ADULT CLIENT [18+ yrs] REGISTRATION FORM
Client's Last Name: First Name: MI:
Date of Birth [MM/DD/YYYY]: Age: Home Phone:
Address: Work Phone: Work Phone:
Celi Phone:
City: State: Zip:
E-Mail:
Have you been in counseling before? Yes No - If yes, at Council for Relationships? Yes No -
Partner's Last Name: MI: MI:
The following questions provide information which is important to our research, planning and funding efforts. We appreciate your response. If your selection does not appear as an option, please specify your answer in the space provided. The information you supply is confidential and voluntary.
Current Relationship - Please indicate selection from listed options: Time Together [Years]
1. Single 2. Dating 3. Engaged 4. Married 5. Living Together/Domestic Partners 6. Separated 7. Divorced/Annulled 8. Widowed
Children Information — Male Female
Ages of Children from your Current Relationship:
Others in home: Parent/In-Law Grandparent Grandchild Other Family Non Family
Work Status — Please indicate selection from listed options: You: U Your Partner (if not present): U
1. Disabled 2. Employed (Full) 3. Employed (Part) 4. Homemaker 5. Retired 6. Self-employed 7. Student 8. Unemployed
Occupation: Partner: Partner:
Veteran: You ☐ Partner ☐ Yearly Income (all sources): You \$,
Highest Education — Please indicate selection from listed options: You: Your Partner (if not present): 1. Elementary 2. High School/GED 3. Some College 4. College Graduate 5. Technical School 6. Post Graduate
Religion — Please indicate selection from listed options: You: Your Partner (if not present):
1. Agnostic/Atheist 2. Buddhist 3. Catholic 4. Hindu 5. Muslim
6. Jewish 7. Protestant 8. Non-Religious/Secular 9. Other
If other, please specify:
Race — Please indicate selection from listed options: You: Your Partner (if not present):
1. African American/Black 2. American Indian/Alaska Native 3. Asian/Asian American
4. Native Hawaiian/Pacific Rim 5. Caucasian/White 6. Hispanic/Latino 7. Multiracial 8. Other
If other, please specify:
Gender — Please indicate selection from listed options: You: U Your Partner (if not present): U
1. Male 2. Female 3. Other, please specify:
Sexual Orientation — Please indicate selection from listed options: You: U Your Partner (if not present): U
1. Heterosexual 2. Gay 3. Lesbian 4. Bisexual 5. Questioning 6. Other
If other, please specify:
HOW DID YOU HEAR ABOUT US? [please check all that apply] — Self as Previous Client — Other Council Client —
Friend/Relative Media Appearance Brochure Internet Newspaper/Magazine Phonebook/Directory
Council Staff Other Healthcare Provider Clergy EAP Lawyer/Court Social Services
Heard Council Staff Speak/Present: Other: Other:
COUNCIL THREAPIST/OFFICE USE ONLY Intake Date: Office: Client#: Direct: Y N
Therapist: Fee: \$ Fee: \$ Therapy Type: Ind Couple Family Mediation Psychiatric CoParent
Therapy Type: Ind ☐ Couple ☐ Family ☐ Mediation ☐ Psychiatric ☐ CoParent ☐

COUNCIL FOR RELATIONSHIPS - CHILD CLIENT [Under 18 yrs] REGISTRATION FORM
Minor's Last Name: First Name: MI:
Date of Birth [MM/DD/YYYY]: Age: Home Phone: Home Phone:
E-Mail: Cell Phone:
Primary/Mailing Address:
City: State: Zip:
Parent(s)/Guardian(s) — (If divorced, indicate those with legal custody.)
Last Name: First Name: MI: Custody:
Last Name: MI: Custody:
Current School:
School Type: Public Private Home School
Grade Level: High School Grad GED
Current Medication & Dosage —
Prescribing Physician:
Medication: Dosage: Dosage:
Medication: Dosage: Dosage:
Medication: Dosage: Dosage:
Medication: Dosage: Dosage: The following questions provide information which is important to our research, planning and funding efforts. We appreciate your response.
If your selection does not appear as an option, please specify your answer in the space provided. The information you supply is confidential and voluntary.
Religion — Please indicate selection from numbered options:
1. Agnostic/Atheist 2. Buddhist 3. Catholic 4. Hindi 5. Muslim
6. Jewish 7. Protestant 8. Non-Religious/Secular 9. Other
If other, please specify:
Race — Please indicate selection from numbered options:
 African American/Black American Indian/Alaska Native Asian/Asian American Native Hawaiian/Pacific Rim Caucasian/White Hispanic/Latino Multiracial Other
If other, please specify:
Gender — Please indicate selection from numbered options:
1. Male 2. Female 3. Other, please specify:
Sexual Orientation — Please indicate selection from numbered options: 1. Heterosexual 2. Gay 3. Lesbian 4. Bisexual 5. Questioning 6. Other
If other, please specify:
CFR THERAPIST/OFFICE USE ONLY Intake Date: Office: Client#: Direct: Y N
Therapist: Intake: \$ Fee: \$ Client for Bill/Insur: Y N
Therapy Type: Ind Couple Family Mediation Psychiatric Psycho Ed CoParent Parent Coord

CONSENT TO TREATMENT**

Treatment offered by Council for Relationships (Council) is of a voluntary nature, except when mandated by the court, and may be ended by you at any time. When treatment is mandated by the court, it is your responsibility to share the Court Order with your therapist at the outset of treatment, so that the purpose and terms of the therapy can be clarified, including how communications and information about the therapy are to be shared.

Confidentiality is extremely important to us. Information revealed to us during treatment will be kept strictly confidential. There are exceptions to this, however, that include the following:

- If you disclose your intention to inflict physical harm to yourself or another person;
- If you disclose that physical or sexual abuse or serious neglect of a minor child under the care of a Council clinician has occurred;
- If we receive a signed, valid court order requesting records; and
- In addition, Council clinicians (therapists, psychiatrists, counselors, or clinical supervisors) directly involved in your care may communicate with each other about your treatment. If you were seen previously in therapy at Council, your new therapist may review your prior file in order to insure continuity of your treatment.

Psychotherapy is difficult to describe is general terms. Approaches and techniques vary depending on the problems you have identified, who you are as a person and what special qualities you bring to the therapy, and the training and professional experience of your therapist. In addition, there are different modalities of therapy (individual, couple, family, and group) that may be suitable for you. In some instances, an evaluation for medication may be recommended, and a referral to a psychiatrist or other medical professional with prescribing privileges may be made.

Therapy has both benefits and risks associated with it. On the beneficial side, therapy has been shown to produce lasting change and reduce overall feelings of distress. It can be helpful in resolving specific problems and can lead to improved relationships with significant others in your life. There are, however, no guarantees of success. Risks include intermittent feelings of discomfort (such as sadness, guilt, anxiety, or anger) during and after some sessions as problems are brought to the surface. You may be asked to recall difficult and unpleasant aspects of your personal and family history in order to loosen the grip of these past events on your life now. Occasionally, there is a poor fit between client and therapist.

The work begins with an initial evaluation period, lasting from one to five sessions, depending on the presenting issues and the complexity of your situation. Your collaboration in this process is important to its success, including your active participation in clarifying problems and setting treatment goals with your therapist. At the end of the evaluation, your therapist will share with you initial impressions and provide a preliminary treatment plan. In deciding whether you wish to continue in treatment, you should carefully consider this information and your comfort in working with your therapist. If you have any questions or concerns about your therapist's approach or treatment plan, you should freely communicate them to your therapist.

Payment is due at the time of service, unless other arrangements have been made with your clinician. If your account is more than 90 days in arrears, and you have not agreed to a suitable payment plan, Council may use a collection agency to recover payment.

Occasionally, circumstances arise that necessitates cancellation of an appointment. In this instance, notification must be given at least 24 hours in advance of the appointment time. Council will charge the full fee for a missed appointment or one cancelled with less than 24 hours notice.

I understand that if my therapist is unlicensed and/or in training at Council that they will be supervised regularly by a senior clinician.

In a clinical emergency, if you are unable to reach your therapist, please call 911 and/or present yourself to the nearest emergency room for evaluation.

In case of an emergency, you have my permission to contact the following person:

Emergency Contact Inform	nation:	
Name of Emergency Contac	vt	Relationship to client
Contact number(s)		
I have read and understan	d the information above:	
Name and Signature of clien	nt or parent/legal guardian (if un	nder 14 years old) Date
**The consent agreement will lapse in treatment of longer		has been terminated or there is a
	lationships to send an appreciativices (no clinical information wi	ion letter to thank the professional ill be included):
Title: First Name	e:Last Name:_	
Address:		
Website:	Email:	
Please provide your approvi	ng signature:	



4025 Chestnut Street 1st Floor Philadelphia, PA 19104 **215-382-6680 215-386-1743 Fax** www.CouncilForRelationships.org Offices:
University City & Oxford Valley
Center City, Phila.
Avenue of the Arts
Bryn Mawr
Doylestown
Exton
Oxford Valley
Paoli
Spring House
Wynnewood
Voorhees, NJ

CLIENT ACKNOWLEDGEMENT FORM

Pursuant to HIPAA, Council for Relationships is obligated to request that clients sign an acknowledgement that they have received and reviewed our <u>Notice of Policies and Practices to</u> <u>Protect the Privacy of your Health Information.</u> If you would like a copy of this Notice, please request this from our receptionist or your therapist.

NAME OF CLIENT(S)	-
NAME OF PARENT(S)/LEGAL GUARDIANS OF MINOR CHILDREN OR OTHER LEGAL REPRESENTATIVE	
	_
	_
SIGNATURE OF CLIENT(S)	-
SIGNATURE OF PARENT(S)/LEGAL GUARDIANS OF MINOR CHILDREN OR OTHER LEGAL REPRESENTATIVE	
	_
D.A.TIE	_
DATE	



University City Avenue of the Arts Spring House

Doylestown

Oxford Valley Wynnewood Voorhees, NJ

AREAS OF CONCERN QUESTIONNAIRE

INSTRUCTIONS: The following information will help us to understand your concerns. Please take a few minutes to complete this important form. Date: Name: Part 1: Please underline any of the following concerns that apply to you. Part 2: In front of each concern you underline, please rate its severity as: 1 = Mildly distressing 2 = Moderate 3 = Serious 4 = Severe5 = Very severely distressing Family problems Feeling worthless Upset stomach Relationships problems Drawing away from people Headaches Programs at school/work Lack of interest/enjoyment Sweating Health problems Too many drugs Lightheaded/dizzy Too much worry Financial problems Too much alcohol Legal problems Feel negative about the future Too many fears Sad/depressed Hard to make friends Feeling guilty Feeling lonely Feeling angry/frustrated Loss of appetite Loss of weight Nightmares Sexual problems Weight gain Less energy than usual Feel ignored/abandoned Difficulty sleeping More energy than usual Too much pain Quick change of moods Religious/spiritual issues Confused Dwelling on problems Laugh without reason Restless/can't sit still Problems with my breathing Nervous/tense Memory problem Hot or cold spells Panicky See/hear strange things Problems controlling anger or urges Shaky/trembling Feel used by people Feeling suicidal Feeling others are out to get me Hard to trust anyone

Problems controlling my thoughts



APPOINTMENT REMINDER FORM

Council for Relationships can remind you of your next appointment with your clinician by texting, emailing, or calling you. The automated appointment reminder system is in accordance with all confidentiality laws, and in order to protect your privacy, the reminders will come from an email address or phone number that is not linked to the Council. If you would like to receive automated appointment reminders from the Council, please complete and sign this form.

Yes, I want to receive appointment reminders from the Council.	
Please select one of the following contact methods and provide your corresponding email address.	phone number or
Cell phone call:	
Cell phone text:	
☐ Home phone call:	
☐ Home phone text:	
☐ Work phone call:	
☐ Work phone text:	
☐ Email notification:	
Name and Signature	Date

Get More Information from the Council

Join our email list to receive special news from the Council, tips and articles, and

First Name: Last Name: Email Address: Address: City: State: Zip:	information about relationship education programs.				
Email Address:Address:					
Address:					
City: State: Zip:					
Signature:					
Interested in training and education for mental health professionals, students and clerg	ergy?				
☐ Check here to receive information about our professional education programs. ☐ Check here to receive information about our clergy training programs.					

Thank you for joining our mailing list!

