CONFIDENTIAL CLIENT INFORMATION FORM/COUPLES

Colleen Russell, LMFT, LPC, CGP
Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)
San Francisco Bay Area, Marin County, California
Phone: 415-785-3513; email: crussell@colleenrussellmft.com

Name(s): _____

_____ Date: _____

Street Address:_____

City, State: _____

Dates of Birth :
_____; _____

Telephone Numbers: _____; _____

Email Addresses: _____

_____

Emergency Person and Number to Call: _____

Referred By: _____

Previous/Current Psychotherapy or Counseling

For Whom? _____From: _____To: _____Therapist(s) Name(s) _____

For Whom?_____From: _____To: _____Therapist(s) Name(s)_____

Medical Information: (Physical Conditions; Past and Current Medications and dosages):
_____

_____

Married, Year_____Partnership, Year _____Divorced , Year _____

How Long in Current Relationship? _____

Occupation and Position or Current Enrollment in School:

Current: _____; Past: _____

Current: _____; Past: _____

Highest Education: _____Degree: ____ Subject: _____

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What deaths or major losses have you experienced? _____

Self-Pay Agreement: You attest that you may have insurance coverage, but Colleen Russell, LMFT, has opted out of insurance so she can devote more time and attention to clients. She can provide you with an Out of Network bill that you can submit to your insurance company for a possible reimbursement. The initial couple session is 1 ½ hours for a fee of $200; thereafter the fee is $150 for the hour.

Initial: _____ Initial: _____

Fee: We have agreed on a fee of $150.00 per hour or $200.00 for 1.5 hour sessions .

What brings you to therapy?

_____

_____

_____

_____

What are your strengths as a couple?

_____

_____

_____

What are your goals as a couple? And as individuals?

_____

_____

_____

_____

_____

Signatures: Clients and Date

_____