Vicki J. Cathcart, LLC
C&C Counseling Associates
364 South Pine Street, Suite B-240
Spartanburg, SC 29302
Phone: 864/606-4690 FAX: 864/707-2777
E-mail: vicki.cathcart81@gmail.com
Website: www.clearperspectivesfamilytherapy.com

Location: _____ Spartanburg _____ Greer

Date _____ **Client No. _____**

General Information

Client's full name and names of family members living in the household:

Client Name/s	Date of Birth/s	Family Role/s	Social Security Number/s

Street Address (physical address): _____

City: _____ State:_____ Zip Code: _____

Mailing Address *(if different than street address)*: _____

City: _____ State:_____ Zip Code: _____

Telephone Numbers: E-mail Address _____

			Yes or No
Home:		May we leave a message here?	
Work:		May we leave a message here?	
Cell:		May we leave a message here?	
Other:		May we leave a message here?	

☆**Emergency Contact:** Name:_____ Relationship:_____ Phone Number: _____
I give permission for this person to be contacted by Vicki J. Cathcart, LLC in case of an emergency. **Initials**: _____

Average Annual Income (Work, Disability, SSI) – Circle one
$0 - $30,000 **$30,001 - $50,000** **$50,001-80,000** **$80,001 - $100,000** **Above $100,000**

Other Income (Child Support, Alimony, Family Support, etc.)
Annual $ _____ **Monthly $ _____** **Weekly $ _____**

Employment Information:	**Educational Information:**
Occupation:	Last Year of School Completed:
	9 10 11 12 GED
Employer:	
	College:
Length of Employment:	1 2 3 4
Average Hours Worked Per Week:	Other: _____

How did you find me? (please circle all that apply) Online Search Yellow Pages Word of Mouth Direct Referral

Referred by:_____

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CONSENT FOR TREATMENT

I acknowledge that I have received and read the Professional Disclosure Statement for Vicki J. Cathcart, LLC, and consent to receive treatment with the following stipulations:

- My participation (or my minor child's participation) in individual, couples, or family therapy is voluntary.
- I may terminate the therapeutic relationship at any time, and I may discuss any reasons for doing so with my therapist.
- I understand that as a consumer of services, I have a right to choose a therapist with whom I feel comfortable.
- I have the right to ask questions about the services I am receiving.
- I understand that as a consumer of mental health services, I have the right to review my case file, ask any questions, and make any comment, complaint or amendment to the case file.
- I have been advised how to go about this procedure with the SC Labor, Licensing and Regulation Board.
- I understand that all information shared is held in strict confidence and is only released by my written permission to specific persons or institutions for specific reasons.
- I understand that there are exceptions to confidentiality that are mandated by state statute, as noted in the disclosure.
- I have been informed that entering into therapy may lead to significant changes in my life, for which I am solely responsible for the outcome and consequences.

Therapy Release for Consultation

You will be seeing a Marriage & Family Therapist licensed by the State of South Carolina. At times your therapist may request professional consultation about your case by a state licensed supervisor. Supervisors are under the same confidentiality guidelines as the therapist. The law requires consultation as stated above, and if I do not agree to this, I will have to seek therapy elsewhere.

I have read and understood this notice, and I give my consent for treatment.

_____ _____
Signature **Date**

_____ _____
Signature **Date**

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Client History

Date _____ Client No. _____

Client Name: _____ D.O.B.: _____

1. **Physical Health History**

Primary Doctor: _____ Telephone No. _____
Recent illness _____
Surgery _____
Other illness/conditions/disorders _____

Medication Log:

Medication	Dosage	Frequency	Prescribed by	Effective?

Do you take your medication regularly and as prescribed? Yes _____ No _____

2. **Mental Health History**

Have you ever been to therapy before? ___ No ___ Yes
Where _____ When _____
Psychiatrist: _____ Telephone No. _____
Have you seen the psychiatrist in the last 6 months? _____ No _____ Yes
Have you been hospitalized in the last 2 years? _____ No _____ Yes
Facility: _____ Approximate Dates of Treatment: _____
Do you have a family history of mental health issues? _____ No _____ Yes, explain:
_____

3. **Legal History**

Are you experiencing any legal problems at this time? _____ No _____ Yes_____

Are you court ordered for treatment, involved with a DSS case, or applying for disability or plan to apply?

___ No ___ Yes, explain

_____

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Client Concerns

List the problem(s) you want help for in therapy.
For each problem you identify, please list ***when the problem began*** and ***how distressed*** you have been by that problem.

Problem	When it began	Distress Level			
		A little	**Moderate**	**Quite a bit**	**Extreme**
		1	2	3	4
		1	2	3	4
		1	2	3	4

On the following checklist, please indicate problems that are a concern to you about ***YOURSELF***:

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ sexual abuse/rape
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ anger
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision making
- ❑ feeling "stuck"
- ❑ changing in eating habits
- ❑ changing in sleeping patterns
- ❑ changes in motivation or interesting in doing things you'd normally enjoy
- ❑ other (please specify):

_____

Problems that are a concern to you about ***YOUR PARTNER***:

- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ sexual abuse/rape
- ❑ eating disorder
- ❑ relationship problem
- ❑ family relationships
- ❑ parenting
- ❑ excessive alcohol/drugs
- ❑ chronic illness/pain/physical issue
- ❑ sexual problems
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ hearing or seeing things that others don't
- ❑ suicidal thoughts
- ❑ anger
- ❑ grief
- ❑ self-injury/self-mutilation
- ❑ sexual addiction
- ❑ ADD/ADHD symptoms
- ❑ problems with decision making
- ❑ feeling "stuck"
- ❑ changing in eating habits
- ❑ changing in sleeping patterns
- ❑ changes in motivation or interesting in doing things you'd normally enjoy
- ❑ other (please specify):

_____

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Problems that you experienced ***BEFORE AGE 18***:

- ❑ alcohol/drug addiction
- ❑ physical abuse
- ❑ emotional/verbal abuse
- ❑ unwanted touching
- ❑ financial problems
- ❑ sexual abuse
- ❑ divorce
- ❑ emotional distance
- ❑ other (please specify):

Substance Use:

In general, how often do you drink alcohol?

- ❑ Never
- ❑ Less than once a month
- ❑ About once a week
- ❑ Several days per week
- ❑ Daily

Do you drink more now than you used to? ❑ Yes ❑ No

Has anyone objected to your drinking? ❑ Yes ❑ No

Are you using street drugs or have you? ❑ Yes ❑ No

Problems that are a concern to you about ***YOUR RELATIONSHIP***:

- ❑ poor communication
- ❑ argue about finances
- ❑ not enough time together
- ❑ too much time together
- ❑ fighting/arguing
- ❑ physical violence
- ❑ excessive alcohol/drugs
- ❑ refuses sex too often
- ❑ demands sex too often
- ❑ physical sexual problems (impotence, painful intercourse, etc.)
- ❑ parenting differences
- ❑ partner too controlling
- ❑ different values
- ❑ emotional abuse
- ❑ difficulties with in-laws/extended family
- ❑ other (please specify):

_____
_____
_____

Problems that are a concern to you about your ***CHILDREN/FAMILY***:

- ❑ behavior problems
- ❑ drugs/alcohol
- ❑ adolescent pregnancy
- ❑ ADD/ADHD symptoms
- ❑ sexual abuse
- ❑ anxiety or depression
- ❑ divorce adjustment
- ❑ death in family
- ❑ anger
- ❑ peer relationships
- ❑ poor self-esteem
- ❑ bed-wetting/soiling
- ❑ destructiveness
- ❑ issues with step-children/step-parenting
- ❑ eating disorder
- ❑ self-injury/self-mutilation
- ❑ other (please specify):

_____
_____
_____