



Christine A. Livingston M.A., LMFT  
Licensed Marriage & Family Therapist - CA License #90188

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*Hope  
Healing  
Health*

### CLIENT INTAKE FORM

Date \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

\_\_\_\_\_  
(street address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state & zip)

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Gender ☐ Female ☐ Male ☐ Other

Social Security # \_\_\_\_\_

Preferred

ok to leave message?

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

☐☐☐☐☐☐

☐ Yes, it's ok to contact me by email

☐ No, I do not to be contacted by email

If "Yes" checked, I acknowledge and am aware that email is not a confidential means of communication, but I still choose it s a means of communication and accept the risks.

\_\_\_\_\_  
(Signature & Date)

Religious Preference? \_\_\_\_\_

How were you referred? \_\_\_\_\_

Employer \_\_\_\_\_

Length of Employment \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer & Occupation \_\_\_\_\_

Highest level of education completed: ☐ High School

☐ College Degree

☐ Graduate Degree

☐ Professional Training

☐ Field of Study \_\_\_\_\_

Name & Phone of Emergency Contact: \_\_\_\_\_

Relationship to Client \_\_\_\_\_

#### RELATIONSHIP HISTORY

Relationship status: ☐ Engaged ☐ 1st Marriage ☐ Never Married ☐ Separated ☐ Widowed

☐ Re-Married 1, 2, 3 ☐ Shared Living Arrangement

Length of Relationship \_\_\_\_\_

Full name of Children	Date of Birth	Age	In Home?
Others in Home	Relationship	Age	

## MEDICAL AND PSYCHOLOGICAL HISTORY

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Check Up: \_\_\_\_\_

Name of Medications & Prescribed For What? \_\_\_\_\_

Allergies to Medications & Medical Conditions: \_\_\_\_\_

Previous Counseling? ☐ Yes ☐ No Who & How Long? \_\_\_\_\_

For What? \_\_\_\_\_ Outcome? \_\_\_\_\_

Previous psychiatric hospitalization? ☐ Yes ☐ No When? \_\_\_\_\_ Where? \_\_\_\_\_

For What? \_\_\_\_\_

Substance Treatment? ☐ Yes ☐ No When? \_\_\_\_\_ Where? \_\_\_\_\_

Drugs, Alcohol, or Prescription Medication Used/Using \_\_\_\_\_

Circle any issues that pertain to you in the present or underline any issues from the past:

Depression	Feeling Hopeless	Isolating	Thoughts/Plans of Self Harm
Suicide Attempts	Tiredness/Fatigue	Tearful	Difficulty Concentrating
Overeating	Loneliness	Inferiority Feeling	Lack of Enjoyment in Activities
Shy	Difficulty Eating	Sleeping too much	Difficulty Sleeping/Insomnia
Feeling Stressed	Anxious	Nervous	Panic Feeling
Nightmares	Feeling Guilty	Phobias	Blended Family Challenges
Pain	Muscle Tension	Headaches	Fears
Anger	Bowel Problems	Weight Changes	Physical Symptoms
Thoughts of Hurting Others	Irritability	Violent Behavior	Temper
Drug/Alcohol Use/Abuse	Perfectionism	Impulsive	Self-Control Problem
Financial Difficulty	Judgment Difficulty	Difficulty Relaxing	Difficulty Making Decisions
Dealing with Parents	Divorce	Family Conflicts	Relationship Challenges
Peer Conflict	Caretaking Parents	Stomach Aches	Change in Sexual Interest
Job Dissatisfaction	Education Problem	Sexual Problems	Work Performance Problem
Unmotivated at Work	Career Choices	Conflict at Work	Memory Problems
Extreme sadness	Legal Matters	Death	Challenges with Parenting

Reason for seeking help & what you would like to see happen as a result of therapy:

## RESPONSIBLE PARTY:

Private Pay: Responsible Party Name & Address \_\_\_\_\_

☐ Address Same as Above

### **Informed Consent & Contract Agreement for Services**

Welcome! Please read the following regarding my policies. Your understanding of this part of our professional relationship is important. Ask me any questions you have the beginning of our session. Sign this only when you feel you understand it and have all your questions answered. It is my desire that your overall therapy experience is healthy and life giving for you.

1. **Introduction:** I am a Licensed Marriage and Family Therapist, providing services for individuals, couples, and families. My style of therapy invites a collaborative approach, incorporates a view of the whole person, and focuses on recognizing and appropriating strengths, building secure attachment, improving interpersonal connections, and experiencing recovery from trauma. I use a variety of methods to assist clients on their journey to health, healing and hope.

2. **Private Practice:** I am the sole practitioner in private practice and the sole owner. I am affiliated with a group of private practice therapists with common goals and standards that share office space. The professional affiliation with West Roseville Counseling and Debbie McJimsey is solely that of landlord and lessee.

3. **Confidentiality:** Information that you reveal to me is private and it is your right to have that information kept confidential. There are certain situations in which information may be released with or without your permission. These situations are:

1. When you sign a form authorizing me to release information to a specified person or allow me to acquire information from another person.
2. If I have a reasonable suspicion of child abuse or neglect, or see physical signs of elder abuse or the abuse of a dependent adult, a report must be made to the designated protective agency.
3. If you tell me of a serious intent to physically harm another person, then I must warn that person and the police.
4. If you appear to be dangerous to yourself or others, or unable to care for yourself, I will take measures to attempt to ensure your safety which may mean releasing private information to secure assistance from others in creating a safety plan.
5. Information or records may need to be disclosed in the event of a court order.
6. Disclosure of confidential information may be required by your health insurance carrier in order to process claims.

On occasion, I will consult with other professional colleagues about my work in order to provide better service to you. In case of such consultation, your name and any identifying information will be protected.

4. **Therapy Process:** Therapy may result in a number of benefits to you, including improved relationships, a better understanding of your personal goals and values, and resolution of the specific concerns that led you to seek therapy. However, psychotherapy is a joint endeavor, the results of which cannot be guaranteed. I will contribute knowledge, skills and support; however, progress depends on many factors, including your motivation and commitment to your own growth, change and care; honesty and other life circumstances such as your interactions with family, friends and other associates. Sometimes change will be easy and swift and sometimes it will be slow and frustrating. Talking about unpleasant events, feelings or thoughts during therapy may result in discomfort for you. Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions such as fear, anger, sadness, depression, anxiety, frustration, or loneliness. Attempting to resolve the issues that brought you into therapy, such as issues in interpersonal relationships, may result in change not originally intended. Positive change may not be noticeable after each session, but over time change will become apparent as life circumstances become more manageable and self awareness increases.

5. **Shared Information:** If you or your partner should disclose information with me in private, I will encourage you to share this information voluntarily to your partner in our couple's session. If you do not share this information, I may need to share this information in order to preserve my neutral position in our therapeutic relationship.

6. **Appointments:** Therapy sessions are normally 55-60 minutes in length. Your appointments will be scheduled according to availability while making careful effort to accommodate your schedule. Please note that you are reserving time in your name.

**if you cannot make your appointment, please notify me as soon as possibly by voicemail  
(530) 237-9699**

**so that the time may be offered to others waiting to be scheduled.**

Please allow **24 hours advance notice when cancelling a session;** otherwise **you will be charged the usual per hour rate** for your appointment time. Regular attendance is recommended to insure continuity of services and to enhance the effectiveness of the therapy.

**7. Professional Fees and Payments:**

a. Professional Fee - My fee is \$175<sup>00</sup> for a 55 minute session. At times by prior arrangement, sessions may be longer in length and will be pro rated accordingly. The fee is due at the **beginning** of each session unless other arrangements have been made in advance. In order to maximize the use of the therapy hour, please consider the following about your choice of payment.

- If paying by cash, bring in the correct amount of cash for your session
- If paying by check, make it out to "Christine Livingston" prior to your appointment
- Please note, I am not a provider for any insurance company. **I request full payment at the time of your services by cash or check.**
- If your insurance company covers mental health services, I will be happy to provide you with a summary of services upon request that you may then turn in to your provider for possible reimbursement. You will need to check with your provider for eligibility, protocols and rates of reimbursement.

b. Cancellation Fee - **If you need to cancel or reschedule an appointment, you will be charged the full counseling fee for an appointment cancelled less than 24 hours in advance. Exceptions include sudden illness of you or a child and emergencies. Work schedule changes are not an exception.**

c. Telephone Fees - If you need telephone time with me between sessions, please leave a message on my voicemail. I will return your call. If you need more than 5 minutes, please let me know as we will most likely need to schedule a time. My regular fee applies to telephone appointments longer than 5 minutes, prorated.

d. Administrative Fees - Other requests for a letter, treatment summary reports or any other administrative request will be billed at the regular per hour fee, prorated. In the case of a subpoena requesting court appearance, the rate is \$550/hour, due on or before date of court appearance.

e. Increase in Fees - My fees may increase over the course of treatment, but only with prior notification and a discussion with you. I encourage open, honest, communication about the fee arrangement so that both of us are clear on expectations.

**8. Telephone Accessibility and Emergencies:** I will check my voicemails periodically on weekdays and will return your call at my earliest opportunity. If you have not heard back from me in a reasonable amount of time (around 24 hours), call again, because errors do happen with voicemail. I am available by text, however, please limit this means of communication to the scheduling or cancellation of office and phone appointments. Please note: I do not keep client phone numbers in my phone for confidentiality reasons. **It is important when communicating by text that you identify yourself by name.** Since I have voicemail and do not carry a pager, I am not available for emergencies of an immediate nature. In choosing to work with me, it is important that you fully understand this. If you do not have a friend or family member available in an emergency, you can:

- Call 911
- Contact the Sutter Center for Psychiatry Call Center at (916) 386-3000
- Call the Suicide Prevention Hotline at 988

If you have any questions on any of these policies, please discuss your questions with me at our first appointment. Your signature below indicates that you have thoroughly read and understand all the policies covered in this document, that any questions have been addressed to your satisfaction and that you are willing to receive therapeutic services based on these policies.

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Print Name

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Signature

Date

---

Print Name (Additional Client)

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Signature (Additional Client)

Date

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Provider's Signature

Date

**ACKNOWLEDGEMENT OF RECEIPT:  
NOTICE OF PRIVACY PRACTICES**

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received a copy of the Providers 'Notice of Privacy Practices'.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Interpreter (if applicable)

**Written Acknowledgement Not Obtained**

- ☐ Notice of Privacy Practices Given - Patient Unable to Sign
- ☐ Notice of Privacy Practices Given - Patient Declined to Sign
- ☐ Notice of Privacy Practices Mailed to Patient - Awaiting Signature
- ☐ Other Reason Patient Did Not Sign

\_\_\_\_\_  
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