SONOMA SKIES THERAPY
Elisa Straub, MS (702) 823-0541
Marriage and Family Therapist
1180 North Town Center Drive
Las Vegas, Nevada 89144

DATE_____

NAME_____SEX_____DOB_____

ADDRESS_____CITY_____ZIP_____

CELL# _____ HOME #_____ WORK #_____

PLEASE CIRCLE THE NUMBER YOU PREFER FOR CONTACT

S.S. #_____ MARITAL STATUS_____

OCCUPATION_____EMPLOYER_____

EDUCATION_____E-MAIL ADDRESS_____

MAY I CONTACT YOU AT THIS EMAIL TO CONFIRM APPOINTMENTS YES NO

SPOUSE OR PARTNER

NAME_____SEX_____DOB_____

ADDRESS_____CITY_____ZIP_____

CELL# _____ HOME #_____ WORK #_____

PLEASE CIRCLE THE NUMBER YOU PREFER FOR CONTACT

S.S. #_____ MARITAL STATUS_____

OCCUPATION_____EMPLOYER_____

EDUCATION_____E-MAIL ADDRESS_____

MAY I CONTACT YOU AT THIS EMAIL TO CONFIRM APPOINTMENTS YES NO

EMERGENCY CONTACT_____PH #_____

REASON FOR ATTENDING THERAPY_____

Please rate your general satisfactions with life a present (circle one)

Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Please rate your level of satisfaction in present marriage/significant relationship

Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Have you had prior experience in counseling? Yes ( ) No ( )

If yes, please describe with whom, when, how long, and for what: _____

_____

_____

What are three significant problems you face currently?

1. _____

2. _____

3. _____

Is there anything in particular that you want the therapist to know about your situation?

_____

_____

_____

Present Marriage (or significant relationship)

Years known each other ____ Years married ____ Children of this marriage (names/ages)

_____ _____

_____ _____

Have you been married before? ____

Date married _____ Stepchildren (names/ages)

_____

_____

_____

_____

If one or more prior marriage(s), please list below (use back of page if more space is needed):

_____

_____

Your Personal Health

Identify any allergies, significant health problems, or surgeries that you have had, or currently have:

_____

Do you use any medications? Yes ( ) No ( ) Any drug allergies Yes ( ) No ( )

If yes, please describe: _____

Name of your physician: _____

Years & Level of Education: _____

Is Spirituality/Religion important to you? _____

Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( ) _____

Who do you consider as your greatest support? _____

What do you consider your greatest strengths? _____

_____

How did you hear about Therapy?

___www.psychologytoday.com

____Google

____Referred by friend
____Referred by physician
____Saw business card or other advertisement ____ Other, Please specify_____

Medical and Psychological History Form

Client's Name: _____ Date: _____

Section 1 – Personal History: Please indicate whether you have had any of the following symptoms by placing a check next to the "yes" or "no" blank. If you have other symptoms not listed, please inform me.

YES	NO		YES	NO	
___	___	Depressed Mood	___	___	Restlessness
___	___	Less interest in things	___	___	Easily tired
___	___	Less pleasure in things	___	___	Shortness of breath
___	___	Loss of weight	___	___	Rapid heart rate
___	___	Weight gain	___	___	Dizzy or light headed
___	___	Insomnia	___	___	Nausea or abdominal distress
___	___	Early morning awakening	___	___	Inability to control thoughts/actions
___	___	Agitation	___	___	Being keyed up or on edge
___	___	Loss of energy	___	___	Trouble with concentration
___	___	Feeling of low self-esteem	___	___	Irritability
___	___	Feelings of guilt	___	___	Starving yourself
___	___	Forgetfulness	___	___	Food binges
___	___	Suicidal thoughts	___	___	Voluntary vomiting
___	___	Racing thoughts	___	___	Sexual problems
___	___	Seeing visions	___	___	Multiple body pains
___	___	Hearing voices	___	___	Problems with alcohol
___	___	People plotting against you	___	___	Problems with prescription drugs
___	___	Obsessions	___	___	Problems with street drugs
___	___	Feelings of being controlled	___	___	Hospitalized: drugs or psychiatric
___	__	Multiple thoughts	___	___	Previous psychiatric counseling/care
___	___	Fears	___	___	Current couple problems
___	___	Panic attacks	___	___	Physical, sexual, emotional abuse
___	___	Feelings of anxiety or nervousness	___	___	Uncontrollable anger
___	___	Recent loss of loved one	___	___	Uncontrollable crying

Section 2 - Brief Drug History: Please record your drug history by checking any that apply to you.

Past	Present		Past	Present	
___	___	Alcohol	___	___	Cocaine
___	___	Marijuana	___	___	Opiates
___	___	LSD	___	___	Inhalants
___	___	Methamphetamines	___	___	Others

Section 3 - Family History: Please indicate which family member has or has had a problem.

YES	NO		Family Member	YES	NO		Family Member
___	___	Heart trouble	_____	___	___	Diabetes	_____
___	___	Nervous conditions	_____	___	___	Cancer	_____
___	___	Sexual Abuse	_____	___	___	Depression	_____
___	___	High blood pressure	_____	___	___	Physical/Emotional Abuse	_____
___	___	Suicide/Suicide Attempt	_____	___	___	Drugs/Alcohol Problem	_____

INFORMATION/INFORMED CONSENT AGREEMENT

Therapist Copy

As a Marriage and Family Therapist, I am dedicated in providing quality mental health care services to individuals, families and couples experiencing distress. Please take a moment to read about my policies and procedures while signing the informed consent agreement located at the end of this document. If you have any questions, please ask me at any time.

Services

I provide individual, couple and family therapy for the greater Las Vegas area. It is my responsibility to make recommendations that are in the best interest of you. If I feel your case is beyond my scope of practice, I may refer to you to another therapist or agency that will best assist you.

Appointments

Appointments are approximately 50 minutes long and any additional time needed should be scheduled for another session. Appointments, cancellations and or changes to scheduled appointments can be made through these modes of communication: email, text and or phone call/voicemail to me during regular business hours. Please refer to my communications policy for further questions.

Cancellations

Any cancellations to a scheduled appointment must be made 24 hours in advanced to the scheduled time. If appointments are not canceled within 24 hours, a full session fee will be charged for the late notice. If you miss two consecutively scheduled appointments, your appointment slot can be given to another client. I understand that life happens and things come up, therefore you will be given one late cancellation without being charged a fee.

Fees

Fees are payable prior to the start of or end of each session. I accept cash, check or major credit cards.

Privacy of Information

It is my policy not to release any information regarding your use of my services, and or any personal matters discussed with me. Confidentiality is assured except in the following situations listed below:

a.) If you authorize me to release your records or other information to another agency or professional and or to individual of your choice. This may only be done with your written consent.

b.) In the event that there is clear imminent danger to you or another person, this includes; if you are considered to be highly suicidal, we are required by law to report pertinent information to authorities. This also includes reporting child or elder abuse or neglect.

Termination

Please inform me if you are planning to discontinue treatment for any reason. The final session is an important part of the therapeutic process and should be discussed in advance, just as any mutually agreed up decision.

Risks/Benefits

Therapy has been demonstrated to help many individuals, families and couples. This is particularly true when you and or your family sincerely desires positive change to occur and you follow through with homework and or other activities that you and your therapist agree would be helpful to you/all. If counseling does not result in the change you hoped for, I recommend that you discuss this with me so that I can help you decide whether to discontinue therapy, try an alternative treatment techniques, or seek alternative help. The primary risk of therapy is that the process may involve discussing distressful symptoms and or life events that may evoke unpleasant feelings. If this occurs it is important to let me know so that I can help you deal effectively with those concerns.

Elisa Straub, Marriage and Family Therapist

I have read and understand the nature and limits of the services that Ms. Straub provides and voluntarily agree to participate in therapy.

Client Signature: _____ Date: _____

Spouse Signature:_____ Date:_____

Parent Signature: _____ Date:_____

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