

VICTORIA SCIARRA, LMFT  
4182 VIKING WAY, SUITE 204  
LONG BEACH, CA 90808  
562.420.3002

## CONFIDENTIAL CLIENT INFORMATION

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE: H: \_\_\_\_\_  
W: \_\_\_\_\_ Cell: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT & PHONE NO: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_ MAY I THANK THEM: Y\_\_ N\_\_

### **RELATIONSHIPS:**

YEARS IN CURRENT MARRIAGE/PARTNERSHIP: \_\_\_\_\_

Marital Status: ( ) Single ( ) Married ( ) Dom. Part. ( ) Live In ( ) Divorced

NUMBER OF PREVIOUS MARRIAGES/RELATIONSHIPS:  
\_\_\_\_\_

SPOUSE/PARTNER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

Statement about the nature of relationship (friendly, distant, loving, hostile)  
\_\_\_\_\_  
\_\_\_\_\_

NAMES & AGES OF CHILDREN: \_\_\_\_\_

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NAMES & AGES (OR YEAR & CAUSE OF DEATH) OF PARENTS: \_\_\_\_\_

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**FAMILY HISTORY OF ALCOHOLISM, DRUG ABUSE, MENTAL ILLNESS, VIOLENCE, ILLNESS:** \_\_\_\_\_

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**SUBSTANCE USE/ABUSE PAST/PRESENT:** \_\_\_\_\_

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**MEDICATIONS:** List what you are presently taking and for what.

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**CHILDHOOD ILLNESS/DISEASES/TRAUMAS:** (injuries, hospitalizations, etc.)

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**ADULT MAJOR TRAUMAS:** (relational, illnesses, injuries, hospitalizations, etc.)

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**SUICIDE ATTEMPT/S OR VIOLENT BEHAVIOR** (describe: age, circumstances, how, etc.) \_\_\_\_\_

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**PREVIOUS THERAPY:** (Please describe reason for going, when, was it helpful, why it ended and your opinion about the outcome). \_\_\_\_\_

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**PRESENTING PROBLEM** (please be as specific as you can: when did it start, how does it affect you?) \_\_\_\_\_

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Severity of the above problem: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ Very Severe \_\_\_\_\_

**MEDICAL DOCTOR(S) (PSYCHIATRIST) NAME & PHONE #:** \_\_\_\_\_

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**WHAT WOULD YOU LIKE TO WORK ON IN THERAPY?** \_\_\_\_\_

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**PLEASE LIST 3 THERAPY GOALS YOU HAVE**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**HOW WILL YOU KNOW WHEN YOU'VE REACHED THEM?** \_\_\_\_\_

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**WHAT ELSE WOULD YOU LIKE ME TO KNOW?** \_\_\_\_\_

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## **TREATMENT AGREEMENT**

Thank you for selecting me as your therapist. This document is designed to ensure you have the information you need to clearly understand our professional relationship as well as the policies and procedures of this office. I welcome your questions or comments about our work together.

**WHAT TO EXPECT FROM PSYCHOTHERAPY:** Most people who enter therapy benefit from the experience. Most clients report that the quality of their lives improve and they experience greater satisfaction. However, I cannot guarantee success. It varies on the problems addressed, the effort on your part, and my competence. There are also risks that can occur when you are in psychotherapy. You may experience feelings such as frustration, anger or guilt. Family members, spouses and friends may not like your new behaviors or decisions.

**CONFIDENTIALITY:** The confidentiality of what you tell me is, in general, legally protected. Normally, information can be released only with your written permission. However, there are exceptions: reports may be required in suspected cases of abuse of a child, elderly or disabled persons, or when you may be a danger to yourself or someone else. State law mandates that mental health professionals need to consult with the Department of Social Services to report these situations to the appropriate agency designated to receive such report.

In most legal proceedings you have the therapist/client privilege to protect information about our work. However, certain court proceedings (e.g. if you place your mental health status at issue in litigation initiated by you), actions before the Board of Behavioral Sciences, or other legal activity may limit our ability to maintain confidentiality.

To provide you with the best treatment I can, there may be times when I might seek consultation or supervision from another licensed mental health

professional. Any professional with whom I consult is required to keep confidential the information I talk about, although exceptions to privacy apply to them as well.

Regarding insurance company confidentiality, while I have no control over what they might do with the information necessary for you to obtain reimbursement, I will furnish a diagnosis to them at your request.

Please keep in mind that emails may not be a secure method of communicating with me and confidentiality may be compromised.

**AVAILABILITY & EMERGENCY PROCEDURES:** I work Monday through Thursday. Sessions are 50 minutes unless otherwise agreed upon. To contact me between sessions, please leave a message on my confidential voice mail 562.420.3002. Your call will be returned as soon as practically possible within 24 hours. If there is a life-threatening emergency, call 911 or go to your local emergency room. When I am on vacation I will arrange for another licensed health care professional to be available if you need support.

**PAYMENT:** My session fee is \$150.00 per fifty-minute session. To better utilize your session time, consider making your payment at the beginning of the session. I accept cash or check for payment. Telephone conversations and professional consultations will be charged at the same rate.

**CANCELLATIONS:** I charge the full fee for rescheduled or canceled appointments without 24 hours notice. The exceptions to this are emergencies, such as you or someone in your family becoming ill or gets injured or if you have a cold or flu virus.

**INSURANCE:** If you wish to have insurance pay for your therapy, you will be provided with a super-bill to submit to your insurance carrier. Your insurance is a contract between you, your employer and your insurance company. I am not a party to that contract. Some health insurance companies will reimburse clients for my services and some will not. In accordance with your policy, the insurance company will determine coverage and make any reimbursements for services rendered directly to you.

**EXPERIMENTAL THERAPIES:** If your presenting issues may benefit from new and experimental therapies I use I will inform you of the assessments and protocols involved. These methods are considered experimental because they are not considered standard procedures of care in the traditional therapeutic community. I will ask your permission to use them ahead of time and ask you to sign an Informed Consent document. You have the right not to utilize these therapies as part of your treatment.

**ACKNOWLEDGEMENT AND CONSENT:** I have read, understood and agree to the above policies and statements. I understand that I have the right to terminate therapy with Victoria at any time. I understand at that time, I will be provided names of other qualified professionals whose services I might prefer. If I have any questions or concerns I will bring them up with Victoria before signing this.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent for Energy Psychology Treatment

***Energy Psychology (EP) constitutes a large family of therapeutic approaches that are grounded in mind/body theory. These modalities include work with three major interacting systems: 1) Pathways (meridians and related acupoints); 2) Centers (chakras); and 3) the Biofield (aura). While there are many approaches to working with each of these three aspects independently, Energy Psychology embraces all three interactive energy systems to enhance outcomes for selected clients.***

***EP practitioners seek to follow the client's own innate wisdom about which modality will work best for them. This can be done through the process of muscle testing—a form of applied kinesiology. This process is a way to “tune into” the body's often-unconscious wisdom to find answers to questions about how to proceed throughout EP sessions. This may involve Victoria asking you a question and then applying light pressure to your arm/s to see where the arm muscle holds up to the pressure indicating a “yes” response in most cases and where the muscle naturally relaxes indicating a “no” response in most cases. A few exceptions known as psychological reversal or neurological disorganization, which are imbalances in the body's energy field, can usually be balanced in-session or through “homework”.***

\_\_\_\_\_ I consent to the use of muscle testing to guide our sessions and to the discussion and demonstration of how to correct for psychological reversals or neurological disorganizations that block accurate testing.

\*\*\*\*\*OR\*\*\*\*\*

\_\_\_\_\_ I prefer that Victoria does not touch my arms or body. I understand I can request training in how to self-test to tune into my innate wisdom.

\_\_\_\_\_ I understand that while many psychotherapists and clients are reporting success with these techniques, these methods are innovative and new. Extensive double-blind studies have not yet been done and we cannot guarantee results or make any claims for specific client populations. EP treatments are still considered experimental and I have the right to know about and use more traditional treatments for my particular presenting problem.

\_\_\_\_\_ I agree to contact Victoria should I experience any difficulty or concern after having an EP session. I understand that she will return my call as soon as is practically possible within 24 hours.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_