



MY HEALING PLACE
Adult Group or Individual Therapy
Registration & Information Form

DB
Group:
Therapist:
Termination:

Name _____ Date _____

Daytime Contact # () _____ Alternate Phone # () _____

Mailing Address _____
ADDRESS CITY ZIP

Email _____

Date of Birth (mm-dd-yyyy) _____ Social Security # _____

Place of Work _____ Work Phone () _____

Occupation _____

Emergency Contact Person _____

Emergency Contact Phone # () _____

List the persons currently living with you. Include their names and relationship to you.

Please circle the type of loss...

Death Divorce Separation Abuse Incarceration Deployment Assault Abandonment
Other _____

Date and year that this loss occurred _____

If this is a death loss, briefly describe your relationship to the deceased.

_____ Name of Deceased _____

Please describe the circumstances of the loss that brings you to *My Healing Place*. If this is a death loss, please describe the cause of death.

What brings you to therapy at this particular time?
(if additional space is needed please feel free to write on the back side of this form)

What would you like to gain through participation in grief/trauma therapy at this time?

Please provide details on any *other* significant losses, death and non-death, you have experienced recently.

Who are the people / groups who have supported you during these losses?

What has been most helpful to you in your grief?

Please place a check mark beside any of the following you currently experience and circle any that are severe:

- | | | |
|---|--|--|
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> heightened levels of irritation | <input type="checkbox"/> headaches |
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> high levels of anxiety | <input type="checkbox"/> desire to withdraw |
| <input type="checkbox"/> over eating | <input type="checkbox"/> easily startled | <input type="checkbox"/> increased alcohol use |
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> frequent crying | <input type="checkbox"/> thoughts of self-harm |
| <input type="checkbox"/> difficulty getting up in the morning | <input type="checkbox"/> fatigue | <input type="checkbox"/> increased substance use |
| <input type="checkbox"/> flashbacks related to the loss | <input type="checkbox"/> anger outbursts | |
| | <input type="checkbox"/> stomachaches | |

Are you in individual or group therapy at this time? _____ (Y/N)
If yes, please provide the name and contact information of the therapist.

_____ THERAPIST'S NAME _____ PHONE NUMBER

Have you ever participated in counseling or therapy in the past? _____ (Y/N)
If yes, briefly describe your reasons for seeking help and the outcome of the therapy.

Are you currently under the care of a physician? _____ (Y/N)

_____ DOCTOR'S NAME _____ DOCTOR'S PHONE NUMBER

Please list any prescription medication you are currently taking.

Please tell us anything else that may be helpful for us to know about you and your situation.

How did you find out about My Healing Place?



MY HEALING PLACE Adult Consent for Treatment

I _____, hereby give full consent for myself to receive the services of My Healing Place until I give notification of any changes or until the designated My Healing Place staff therapist determines services are no longer necessary. I understand that if any court reports, court appearances or court consultations are required in association with treatment at My Healing Place, I will be responsible for payment in advance at full fee for these services. I agree to give My Healing Place advance notice of the need for said services. In addition, I understand that as a client of My Healing Place I have the following rights and responsibilities in the therapeutic setting:

- To be treated with dignity and respect.
- To appropriate treatment in the least restrictive setting available consistent with the protection of myself and others
- To give input for my own treatment plans.
- To an explanation of the benefits, effects, alternatives and risks of all treatment.
- To refuse treatment and receive an explanation of possible consequences of refusing, unless the court orders such.
- To meet with the person treating me, and to an explanation of their qualifications, title, and responsibilities.
- To request at my own expense, the opinion of a consultant to review my treatment.
- To my records being kept in a confidential manner. Though they are the property of My Healing Place, I may request access to them by following the policies and procedures for such requests.
- To be free from abuse, neglect, and exploitation.
- To be treated without discrimination.
- To make a complaint about my treatment and rights without such complaints being used against me.
- To be honest, open and willing to share my concerns with my counselor.
- To ask questions when I do not understand or need clarification.
- To report changes or unexpected events as related to my problems with my therapist.

Normal sessions are 50 minutes in length. Payment for each session is due at the time of the visit. You will be charged for all scheduled appointments unless cancellation notice is received AT LEAST 24 HOURS PRIOR to the appointment time so that the time may be rescheduled.

My records and/or any information conveyed by myself and/or members of my family to personnel at My Healing Place will not be released without my written permission unless required by Texas law. (Reporting alleged or suspected incidents of child or elderly abuse, suicidal ideation or gestures, sexual exploitation by a therapist or threats of harm to self or others is mandatory under the Texas Family Code.)

Signature of Client

Date

Signature of Therapist/Witness Date

Date



Limits of Confidentiality

Information discussing the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and /or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

Client signature (or guardian if under 18)

Date

Name of Client (or guardian if under 18)

Signature of MHP Therapist