



**MY HEALING PLACE**  
**Couples 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the current situation of your relationship feel?

\_\_\_\_\_  
\_\_\_\_\_

What would you like to gain through participation in couples therapy at this time?

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Are you in individual or group therapy at this time? \_\_\_\_\_ (Y/N)

If yes, please provide the name and contact information of your therapist.

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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.

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

If yes, please give us the name and phone number of your physician.

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DOCTOR'S NAME

PHONE NUMBER

Please list any prescription medication you are currently taking.

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

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How did you find out about My Healing Place?

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**Loss History**

Please provide details on any death losses you have experienced, including your relationship to the deceased, how they died, and the date of their death.

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Please provide details on any non-death losses you have experienced recently. A non-death loss may include divorce, separation, abuse, job-related, incarceration, deployment, assault, abandonment, or another loss. Please provide dates for these losses.

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

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What has been most helpful to you in your grief?

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## 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