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Self in Context Psychotherapy

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Before Your First Appointment

Hello, and welcome to therapy. Before we begin, I would like to get to know a little about you and the questions and concerns you will bring to therapy. I must also give you information about me and my practice so that you can make an informed decision about engaging in therapy with me. I have created this packet of materials so that you may complete these forms and review the necessary information in advance of our first meeting, so that we can use our time talking and beginning the work of therapy and not filling out paperwork.

Please return the following:

- Client Information Questionnaires
- Current Symptoms Checklists (2)
- Informed Consent for Treatment – please sign the second page
- Schedule with preferred times marked

First and Ongoing Appointments

My office is currently open four days each week, with some evening and weekend hours by special appointment. If we have not already scheduled a first meeting, you may call me to set up an appointment at 503-421-1597. Please leave your name and number and the best times to reach you in your message.

I look forward to seeing you soon,

Siri Hoogen, PhD
Licensed Psychologist

COUPLE INFORMATION QUESTIONNAIRE

Welcome to my practice. Please complete the following questionnaire to help me plan therapy services for you. If you need clarification on any question, please do not hesitate to call me. All information gathered here is held in strictest confidence.

Full Name Client A: _____ Today's Date: _____

Street Address: _____

City: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Which number do you prefer I call 1st _____ 2nd _____ 3rd _____

Email: _____ Age: _____ Birth Date: _____

Occupation/Job Title: _____

Employer/School: _____

Your Education: _____

Religious Preference: _____ Active/Inactive

Who is your primary care physician? _____

Address: _____

Phone: _____ Fax: _____

Date of your last physical: _____

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I notify your physician about the issues for which you are seeking psychotherapy? yes no Please initial here: _____

List any health concerns for which you are currently receiving treatment:

Allergies or adverse reactions to medication or treatment: _____

List any medications you are currently taking:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed by</u>	<u>Start Date</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Full Name Client B: _____ Today's Date: _____

Street Address: _____

City: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Which number do you prefer I call 1st _____ 2nd _____ 3rd _____

Email: _____ Age: _____ Birth Date: _____

Occupation/Job Title: _____

Employer/School: _____

Your Education: _____

Religious Preference: _____ Active/Inactive

Length of current relationship: _____

Who is your primary care physician? _____

Address: _____

Phone: _____ Fax: _____

Date of your last physical: _____

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I notify your physician about the issues for which you are seeking psychotherapy? yes no Please initial here: _____

List any health concerns for which you are currently receiving treatment:

Allergies or adverse reactions to medication or treatment: _____

List any medications you are currently taking:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed by</u>	<u>Start Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Individual Symptoms (A)

Name: _____

Please **circle the number** to indicate the degree to which the following feelings and behaviors are troubling your current life. Also, **in the blank**, indicate **how long** these problems have affected you. Please rate all symptoms.

Scale **1 = extremely big problem for me** **6 = little or no concern to me**

MOOD	1 2 3 4 5 6 _____	Pregnancy loss	1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____	Chronic disease	1 2 3 4 5 6 _____
Inferiority Feelings	1 2 3 4 5 6 _____	Terminal condition	1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____	THOUGHTS	1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____	Making Decisions	1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____	Memory	1 2 3 4 5 6 _____
	amount in last month _____	Confusion	1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____	Communicating	1 2 3 4 5 6 _____
Nightmares	1 2 3 4 5 6 _____	IMPULSE Control	1 2 3 4 5 6 _____
Insomnia	1 2 3 4 5 6 _____	Anger	1 2 3 4 5 6 _____
Ambition	1 2 3 4 5 6 _____	Temper	1 2 3 4 5 6 _____
Unhappiness	1 2 3 4 5 6 _____	Hurting others	1 2 3 4 5 6 _____
Irritability	1 2 3 4 5 6 _____	Hurting self	1 2 3 4 5 6 _____
Depression	1 2 3 4 5 6 _____	Food management	1 2 3 4 5 6 _____
Manic Behavior	1 2 3 4 5 6 _____	Dangerous behavior	1 2 3 4 5 6 _____
Suicidal Thoughts	1 2 3 4 5 6 _____	Attention Deficit	1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____	Medication _____	
Nervousness	1 2 3 4 5 6 _____	SUBSTANCE USE	1 2 3 4 5 6 _____
Panic Attacks	1 2 3 4 5 6 _____	Alcohol	1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____	Drinks/week	_____
Obsessive Thoughts	1 2 3 4 5 6 _____	Drugs	1 2 3 4 5 6 _____
Fears	1 2 3 4 5 6 _____	Substance(s) used _____	
	Specific phobia	Caffeine	1 2 3 4 5 6 _____
HEALTH	1 2 3 4 5 6 _____	Drinks/week	_____
Bowel Troubles	1 2 3 4 5 6 _____	Tobacco	1 2 3 4 5 6 _____
Headaches	1 2 3 4 5 6 _____	Packs/week	_____
Stomach Trouble	1 2 3 4 5 6 _____	RELATIONSHIPS	1 2 3 4 5 6 _____
Binging/Purging	1 2 3 4 5 6 _____	Problems with friends	1 2 3 4 5 6 _____
Infertility	1 2 3 4 5 6 _____	Problems with partner	1 2 3 4 5 6 _____

Separation/Divorce	1 2 3 4 5 6 _____	Finances	1 2 3 4 5 6 _____
Problems with family	1 2 3 4 5 6 _____	Stress	1 2 3 4 5 6 _____
Loss of someone	1 2 3 4 5 6 _____	TRAUMA	1 2 3 4 5 6 _____
Who? _____		Vehicular accident	1 2 3 4 5 6 _____
Shyness	1 2 3 4 5 6 _____	Natural disaster	1 2 3 4 5 6 _____
Loneliness	1 2 3 4 5 6 _____	History of abuse	1 2 3 4 5 6 _____
Fear of being alone	1 2 3 4 5 6 _____	Physical	1 2 3 4 5 6 _____
Distancing others	1 2 3 4 5 6 _____	Emotional	1 2 3 4 5 6 _____
SEXUAL Problems	1 2 3 4 5 6 _____	Sexual	1 2 3 4 5 6 _____
SELF CARE	1 2 3 4 5 6 _____	Incest	1 2 3 4 5 6 _____
Work	1 2 3 4 5 6 _____	Physical assault	1 2 3 4 5 6 _____
Career Choices	1 2 3 4 5 6 _____	Sexual assault	1 2 3 4 5 6 _____
Education	1 2 3 4 5 6 _____	Current abuse	1 2 3 4 5 6 _____
Legal Matter	1 2 3 4 5 6 _____	Domestic violence	1 2 3 4 5 6 _____

List any other concerns you may have at this time:

ADDITIONAL QUESTIONS

What do you do for relaxation and enjoyment?

How much attention do you pay to your physical health? Please explain.

What do you value most in life?

If "everything were better" in your life, what would that look like?

Current Individual Symptoms (B) Name: _____

Please **circle the number** to indicate the degree to which the following feelings and behaviors are troubling your current life. Also, **in the blank**, indicate **how long** these problems have affected you. Please rate all symptoms.

Scale **1 = extremely big problem for me** **6 = little or no concern to me**

MOOD	1 2 3 4 5 6 _____	Infertility	1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____	Pregnancy loss	1 2 3 4 5 6 _____
Inferiority Feelings	1 2 3 4 5 6 _____	Chronic disease	1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____	Terminal condition	1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____	THOUGHTS	1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____	Making Decisions	1 2 3 4 5 6 _____
	amount in last month _____	Memory	1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____	Confusion	1 2 3 4 5 6 _____
Nightmares	1 2 3 4 5 6 _____	Communicating	1 2 3 4 5 6 _____
Insomnia	1 2 3 4 5 6 _____	IMPULSE Control	1 2 3 4 5 6 _____
Ambition	1 2 3 4 5 6 _____	Anger	1 2 3 4 5 6 _____
Unhappiness	1 2 3 4 5 6 _____	Temper	1 2 3 4 5 6 _____
Irritability	1 2 3 4 5 6 _____	Hurting others	1 2 3 4 5 6 _____
Depression	1 2 3 4 5 6 _____	Hurting self	1 2 3 4 5 6 _____
Manic Behavior	1 2 3 4 5 6 _____	Food management	1 2 3 4 5 6 _____
Suicidal Thoughts	1 2 3 4 5 6 _____	Dangerous behavior	1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____	Attention Deficit	1 2 3 4 5 6 _____
Nervousness	1 2 3 4 5 6 _____	Medication _____	
Panic Attacks	1 2 3 4 5 6 _____	SUBSTANCE USE	1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____	Alcohol	1 2 3 4 5 6 _____
Obsessive Thoughts	1 2 3 4 5 6 _____	Drinks/week	_____
Fears	1 2 3 4 5 6 _____	Drugs	1 2 3 4 5 6 _____
Specific phobia	1 2 3 4 5 6 _____	Substance(s) used _____	
HEALTH	1 2 3 4 5 6 _____	Caffeine	1 2 3 4 5 6 _____
Bowel Troubles	1 2 3 4 5 6 _____	Drinks/week	_____
Headaches	1 2 3 4 5 6 _____	Tobacco	1 2 3 4 5 6 _____
Stomach Trouble	1 2 3 4 5 6 _____	Packs/week	_____
Binging/Purging	1 2 3 4 5 6 _____	RELATIONSHIPS	1 2 3 4 5 6 _____

Problems with friends	1 2 3 4 5 6 _____	Legal Matter	1 2 3 4 5 6 _____
Problems with partner	1 2 3 4 5 6 _____	Finances	1 2 3 4 5 6 _____
Separation/Divorce	1 2 3 4 5 6 _____	Stress	1 2 3 4 5 6 _____
Problems with family	1 2 3 4 5 6 _____	TRAUMA	1 2 3 4 5 6 _____
Loss of someone	1 2 3 4 5 6 _____	Vehicular accident	1 2 3 4 5 6 _____
Who? _____		Natural disaster	1 2 3 4 5 6 _____
Shyness	1 2 3 4 5 6 _____	History of abuse	1 2 3 4 5 6 _____
Loneliness	1 2 3 4 5 6 _____	Physical	1 2 3 4 5 6 _____
Fear of being alone	1 2 3 4 5 6 _____	Emotional	1 2 3 4 5 6 _____
Distancing others	1 2 3 4 5 6 _____	Sexual	1 2 3 4 5 6 _____
SEXUAL Problems	1 2 3 4 5 6 _____	Incest	1 2 3 4 5 6 _____
SELF CARE	1 2 3 4 5 6 _____	Physical assault	1 2 3 4 5 6 _____
Work	1 2 3 4 5 6 _____	Sexual assault	1 2 3 4 5 6 _____
Career Choices	1 2 3 4 5 6 _____	Current abuse	1 2 3 4 5 6 _____
Education	1 2 3 4 5 6 _____	Domestic violence	1 2 3 4 5 6 _____

List any other concerns you may have at this time:

ADDITIONAL QUESTIONS

What do you do for relaxation and enjoyment?

How much attention do you pay to your physical health? Please explain.

What do you value most in life?

If "everything were better" in your life, what would that look like?

INFORMED CONSENT FOR TREATMENT/ CONFIDENTIALITY

As a client, you have rights and responsibilities when you seek my consultation, including:

1. THE RIGHT OF CLIENTS TO REFUSE TREATMENT. You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are unhappy with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another practitioner.
2. THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HER/HIS NEEDS. I will make an assessment and suggest possible treatment modes that may be helpful to you. However, the choice of treatment mode remains with you. If at any time you feel dissatisfied with the therapy, your questions and concerns must be addressed before we can continue.
3. THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW. Under Oregon state law psychologists have an obligation to honor client confidentiality. **Nothing you tell me can be told to anyone else without your permission.** HOWEVER, THERE ARE EXCEPTIONS, SOME OF WHICH ARE:
 - CHILD ABUSE - I am required to report any known or suspected child abuse to the Department of Human Services.
 - HARM TO ANOTHER - If I believe a client is about to harm another person, I have a duty to warn and, insofar as possible, to protect the intended victim.
 - SUICIDE - If I believe someone is immediately likely to harm her/him self, I will try to protect the person by notifying a family member, the police, or the Mental Health Department.
 - EVALUATIONS - If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, or physician), I will routinely send a written report of my findings to that professional. I will obtain a written consent from you in advance authorizing me to make such a disclosure.
 - COLLECTION PROBLEMS - If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with other information that may help make collection possible.

FEES – ADDITIONAL CHARGES – BILLINGS--OFFICE POLICIES PROFESSIONAL FEES

My fees are based on the amount of professional time spent or reserved. The basic fee for a therapy hour (50 minutes) is \$140 for individual and couple/family psychotherapy and \$190 for extended sessions. Group psychotherapy (1 ½ hours) is \$75 a session. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at \$140/hour. Psychological assessments, testing, and/or questionnaires are priced individually. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

ADDITIONAL CHARGES - You will also be charged for the following. Each charge is payable immediately upon demand.

- \$15 for any check submitted to me to pay any sums for which you are obligated

and which check is dishonored.

- A delinquency fee of \$25 in the event you fail to timely pay me any sum you owe and I elect to institute or turn your debt over to a collection agency for collection. If I initiate a collection action and prevail, I will also seek such reasonable attorney fees as the court allows.
- \$140 should you fail to keep an appointment and fail to give me 24 hours advance notice that you will not keep such appointment.
- Phone sessions are available (\$140) but insurance cannot be billed for this service.

BILLINGS - I request that you pay for your portion of services at the time of your session unless you request I bill you monthly, in which case the bill is due and is payable immediately upon demand. There is a \$5 service fee for billing which I will add to your charges that I billed.

MISSED APPOINTMENTS - The time scheduled for you is reserved exclusively for you. If you do not keep the appointment, no one else will be able to use the time. Therefore, I ask that you please give me 24 hours notice if you need to cancel an appointment. In all events, please call as soon as you know that you will not be able to keep a scheduled appointment. My voice mail is accessible at all hours.

EMERGENCIES- Should you find yourself in need of emergency assistance during hours when my office is closed, call **my home office at 513-461-9727**. If I am not available, you may call the **Crisis Line at 503-988-4888** 24 hours a day or your local emergency room.

MY TRAINING, BACKGROUND AND ORIENTATION-

I earned my M.A. and Ph.D. in Clinical Psychology from Miami University in 2010. I am a Licensed Clinical Psychologist in the state of Oregon. To continue my growth and education, I complete a minimum of 25 hours a year of continuing education credit, as required by the Oregon Licensing Board. I operate from a mostly feminist constructivist theoretical orientation, which essentially means I am concerned with how people make sense of their lives and how they find the power to change the aspects of their lives that give them dissatisfaction or pain. Please do not hesitate to ask me about any of my policies, beliefs, or my psychological orientation.

I, _____, HAVE READ AND UNDERSTOOD ALL THE FOREGOING AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.

Signature of client

Date

Signature of client

Date

Schedule Information

Please return this page so I can know your schedule. This will assist me in making a regular appointment time with you and will also help me in the event that we need to reschedule a missed or canceled appointment.

Name _____ Date _____

Times I am available to schedule regular appointments:

Preferred times for appointments mark with ✓

Available times mark with ✕

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>
__ 10:00 AM	__ 10:00 AM	__ 10:00 AM	__ 10:00 AM
__ 11:00 AM	__ 11:00 AM	__ 11:00 AM	__ 11:30 AM
__ 12:00 PM	__ 12:00 PM	__ 12:00 PM	__ 12:00 PM
__ 1:00 PM	__ 1:00 PM	__ 1:00 PM	__ 1:00 PM
__ 2:00 PM	__ 2:00 PM	__ 2:00 PM	__ 2:00 PM
__ 3:00 PM		__ 3:00 PM	__ 3:00 PM
__ 4:00 PM		__ 4:00 PM	
__ 5:00 PM			
__ 6:00 PM			
__ 7:00 PM			

I occasionally have some hours available on other evenings and on Saturday mornings. Due to variation in my own schedule I am not scheduling regular or reoccurring appointments at these times, but I will make appointments during those hours as necessary on a week-by-week basis. Please let me know if you are interested in or limited to late afternoon, evening, or weekend hours and I will do my best to accommodate you.

Please also let me know if your schedule changes so that you need to arrange for a different regular meeting time.