CONFIDENTIAL CLIENT INFORMATION FORM/DV SURVIVOR

Colleen Russell, LMFT, LPC, CGP
Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)
San Francisco Bay Area, Marin County, California
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Name:
____ Date: __________

Street Address :
____

City, State: _______________________________________

Date of Birth: _____________________________________

Telephone: (H) : ____________________(W): ___________________ (Cell): ________________

Email: ____

Emergency Person and Number to Call: ____

Referred By: ____

Previous/Current Psychotherapy or Counseling From: ________To: ______________________________
____

Medical Information: (Past and Current Medications and dosages, When began, Conditions):
____

____

Single___ Married/When____ ___Partnership/When_____Divorced /Separated ______When? _____

How Long in Abusive Relationship? ________________________ When did you leave the Abusive Relationship? ___________________________ What led to you leaving? _______________________
____

Children's Names and Children's Age:
____

Custody Agreement: ____

Occupation and Position or Current Enrollment in School: (Current) ______________________________

(Past) ____

Highest Education: _________________ Degree: _______________ Subject: ___________________

What deaths or major losses have you experienced and When?

____

What was the date(s) of the spousal/partner violence? And What occurred?

____
____
____

When did the spousal/partner psychological abuse and or violence begin? What occurred, (financial, physical, psychological, sexual abuse/violence?

____
____
____

Did you file a restraining order? _______When?Month/Year _______ Was the Abuser incarcerated?________
When? Month/Year ____________________Was he released from custody, When? Month/Year ___________
Where is the abuser now? ____
____

Do you expect to have any contact with the abuser ? ____

Do you have any medical insurance or are you registered with CalVictim's Compensation Plan? Yes__No____

Name of Insurance ______________________Member Number : _____________________________

Insurance Phone Number (On Back of Card) ____

CalVCP Application Number: ______________________________

Self-Pay Agreement: You attest that you (circle): a) do not have insurance coverage, b) have insurance coverage but choose not to use it, and understand that in so doing you are waiving any right to reimbursement; or c) have insurance coverage, but understand that counseling or psychotherapy services provided by Colleen Russell, LMFT, are not covered by the plan. You may send your insurance company a statement for coverage for an out of network provider.

Fee: We have agreed on a fee of ____

What brings you to therapy or counseling now? ____
____
____
____

____

Signature Client: Date: