JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT
ADULT INTAKE

PERSONAL HISTORY

1. Name _____
   Address _____
   City, State, Zip _____

2. Cell Phone (_____)_____
   E-mail _____

3. Can I contact you through:
   Cell phone voice & text ☐ Yes ☐ No
   E-mail ☐ Yes ☐ No

4. Date of Birth _____ Age _____

5. Religion _____
6. Ethnic Group _____
7. Highest education completed _____

WORK HISTORY

8. Employment Status: ☐ Part-time ☐ Full-time
   Employer _____
   Job Title _____
   Work Hours _____AM/PM to _____AM/PM

9. Length of Service _____

10. Job Satisfaction
    ☐ Satisfied ☐ Neutral ☐ Dissatisfied

11. Any change in work responsibilities in the past year? ☐ No ☐ Yes (explain)

_____
_____
_____

12. Were you referred to Jennifer Sigman LMFT - Orlando Therapy Project? ☐ Yes ☐ No

    If Yes, who referred you?
    ☐ Family Member
    ☐ Dr/Medical
    ☐ Former Client
    ☐ Friend
    ☐ Other _____

    If No, how did you hear about my practice?
    ☐ Internet search
    ☐ Social Media
    ☐ Building Sign
    ☐ Other _____

13. Please describe the primary issue bringing you to therapy

_____
_____
_____

14. When did this issue intensify? _____

15. Have you experienced any major life changes in the past year?
    ☐ No ☐ Yes (explain):

_____
_____
_____

    Has this problem affected your ability to do your job? ☐ No ☐ Yes (explain):

_____
_____
_____

JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT
ADULT INTAKE

RELATIONSHIP / FAMILY HISTORY

16. Relationship Status
    - ☐ Single
    - ☐ In Relationship ___ YRS ___ MTHS
    - ☐ Married ___ YRS ___ MTHS
    - ☐ Separated ___ YRS ___ MTHS
    - ☐ Divorced ___ YRS ___ MTHS
    - ☐ Widowed ___ YRS ___ MTHS

17. Name of significant other

_____

18. Significant other's age _____

    Ethnic Group _____

    Occupation _____

19. Name(s) of Children Age Gender

_____ ____ ____
_____ ____ ____
_____ ____ ____
_____ ____ ____

20. Who do you turn to when you have a problem?

_____

THERAPY HISTORY

21. Have you ever had out-patient or in-patient counseling? ☐ No ☐ Yes (explain):

_____
_____
_____

22. Counselor Name

_____

23. Agency Name

_____

24. Identified Problem

_____

25. Length of Counseling

_____

26. Last Session Date (approx.)

_____

27. Was it helpful? If so, how?

_____
_____
_____

Other place(s) where help was sought

_____
_____

28. What's your primary goal for counseling?

_____
_____
_____

TRAUMA HISTORY

29. Have you ever been the victim of sexual assault (rape, incest, sexual abuse)? ☐ No ☐ Yes

30. If yes, did you receive treatment? ☐ No ☐ Yes

    Where / when _____

31. Has there been physical or emotional trauma in your life - past or present? ☐ No ☐ Yes

    If yes, please describe

_____
_____
_____

32. If yes, did you receive treatment? ☐ No ☐ Yes

    Where / when? _____

JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT
ADULT INTAKE

MEDICAL HISTORY

33. Are you now or have you ever taken medications for depression, anxiety or any other behavioral health condition? ☐ No ☐ Yes
If yes, explain

34. Have you ever sought treatment for drug or alcohol use/abuse? ☐ No ☐ Yes
If yes, when and where?

35. Physician's Name

36. Phone Number

37. Is your physician currently treating you for a medical / behavioral health condition?
☐ No ☐ Yes
If yes, explain

38. Are you currently taking any medication(s) (prescription or nonprescription) on a regular basis?
☐ No ☐ Yes
If yes, explain

39. Medication | Reason | Dosage | Frequency

40. All mood/mind-altering substances, including alcohol, you're using or have used within the past year

Type of Substances | Frequency | Quantity

41. Has there been any change in your health in the past year? ☐ No ☐ Yes (explain)

42. Please list any accidents and/or hospitalizations

43. Do you have a history of head trauma, seizures, or any other relevant medical condition?

Thank you.

JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT

PRE-AUTHORIZED BILLING FORM

I authorize Orlando Therapy Project to keep my credit card information stored in a secured and encrypted database. I understand that charges will only be made to my card for the following reasons:

- **Appointments attended.** (*If this is your intended payment method.*)
- **Insufficient funds / returned checks.**
- **Charges for missed appointments.**
    - Appointments not cancelled with 24 hours advanced notice and No-Shows will be billed as follows:
        - *100% of the time scheduled*

- **Balances of charges owed by me after 5 business days.**

I understand that this information will be destroyed 90 days after our last contact. I may revoke this agreement at any time by providing a request in writing.

I understand and agree to OTPs credit card billing policies.

_____
Signature of Patient or Adult Guardian for Minor

_____
Date

_____
Received by

JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT

SIGNATURE PAGE

*Acknowledgement of **Practice Overview** & **HIPAA** information.*

I have been given access to and fully reviewed, a copy of Orlando Therapy Project's **Practice Overview** found on the www.OrlandoTherapyProject.com website. It explains the appointment / cancellation policy, fee structure, limits on confidentiality and communication. I understand that I can ask questions about this at any time.

I/we have been given access to a copy of Orlando Therapy Project's **HIPAA** overview; **Notice of Privacy Practices to Protect Your Health Information,** found on the www.OrlandoTherapyProject.com website.

_____
Signature of Patient or Adult Guardian for Minor

_____
Date

_____
Received by

JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT

INFORMED CONSENT FOR TELEHEALTH SERVICES

Definition of Telehealth Telehealth involves the use of electronic communications to enable Jennifer Sigman, LMFT – Orlando Therapy Project to connect with individuals/couples using live interactive video and audio communications.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described below.

1. The laws that protect the confidentiality of my personal information, that I have already signed also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.
3. I understand there despite reasonable efforts on the part of Jennifer Sigman, LMFT- Orlando Therapy Project that: the transmission of my information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.
4. Jennifer Sigman LMFT – Orlando Therapy Project utilizes secure, encrypted audio/video transmission software to deliver telehealth.
5. By signing this document, I also agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services.
6. If I am in crisis or in an emergency, I should call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services:
Will be billed at the standard and regular rate.

Patient Consent to the Use of Telehealth:
I hereby state that I have read and understood this document, and I agree to the terms.

_____
Client (Signature/Date)

_____
Therapist (Signature/Date)