Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

CLIENT INFORMATION FORM

Name: _____

Legal Name (if different): _____

Address (and zip code): _____

Date of Birth: _____ Relationship Status: _____

Gender: _____ Pronouns: _____

Occupation or School/Grade: _____

Phone Number: _____

Is it okay to leave a voicemail? (Circle) Yes No

Is it okay to text this number? (Circle) Yes No

Email Address: _____
Note: text and e-mail correspondence are **not** confidential forms of communication.
Please initial if you agree to text and email correspondence: _____ Date: _____

Best way to reach you to discuss appointments? (Circle) Call Text Email

Is it okay to leave a voicemail? (Circle) Yes No

Emergency Contact:_____

Number: _____ Relationship to you: _____

Primary Care Provider: _____

City & State: _____ Phone: _____

How did you hear about our therapeutic services? _____

Client Signature: _____ Date: _____

Guardian Signature (if necessary): _____Date: _____

Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

INFORMATION

Name: _____ **Date of Birth**: _____

The following information helps us powerfully prepare for our session.

If you get stuck at any time, breathe. Email it back to us. We will also go over this in person. So, if anything doesn't get answered, we can do it in our first session.

What are 2 or 3 outcomes that you would like to get out of working with us over time as a collaborator in your healing, empowerment, life and relationship goals, and/or sexuality?

1._____
2._____
3._____

What are 1 or 2 outcomes you would like out of your first session?

1._____
2._____

What do you perceive is in the way of you connecting with your vision of a wonderful life? Extra Points if you can name some of your own patterns, limiting beliefs, or sabotaging behavior.

_____
_____

What do you consider to be your mental and emotional strengths?

_____
_____

FAMILY INFO: Does anyone in your immediate family have a history of: alcohol/substance abuse, anxiety, depression, eating disorders, ADHD, schizophrenia, sexual issues, or suicide?

If yes, please explain here or on back of this page: _____
_____
_____
_____

HOUSEHOLD MEMBERS (not including yourself):

Name	Relationship	Date of Birth

Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

THERAPY HISTORY: (Circle) Yes No

If yes, therapist name? _____ Length of treatment: _____

Reason for treatment: _____

HEALTH

How would you rate your current physical health? (Circle) Poor 1 2 3 4 5 Excellent
How would you rate your current sleeping habits? (Circle) Poor 1 2 3 4 5 Excellent
How often do you exercise? (Circle) Never 1 2 3 4 5 Everyday

MEDICATIONS (If none, skip and move to next question)

Name and Dose	For what?	Prescribed by whom?

Where were you raised? Where have you lived?

_____
_____
_____

What is your religious, spiritual, or cultural context? Is it important to you?

_____
_____
_____

How do you identify in terms of sexuality?

- If under 18, tell us about your curiosities. How open is your family to having age-appropriate conversations about sexuality?
- If over 18, tell us about any concerns, questions, or curiosities about your current style, frequency, or abilities in your preferred sexual expressions? Tell us about your ideal sexuality and/or sexual expression?

_____
_____
_____
_____
_____

If applicable, are you currently in a committed romantic partnership (or would you like to be in one)? How do you feel about your current relationship status?

_____
_____

Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

HISTORY:

On a scale of 1 to 10, please answer the following questions:

- 1 being none
- 10 being severe (or even one time)

1. **How much <u>Emotional/Verbal Abuse</u> did you experience in your family, or environment, in childhood, or life? Scale of 1 to 10** *(Shaming, blaming, guilt, denigrating, yelling, criticizing, neglect of nurturing behavior).* **If you are willing, please explain here**.

_____

_____

2. **How much <u>Physical Abuse</u> did you experience in your family or environment, in childhood, or life? Scale of 1 to 10** (*Hitting, striking, slapping, the belt, the paddle, the brush, the whip, the branch, being thrown, being restrained, being left or neglected, lack of physical affection, being physically threatened).* **If you are willing, please explain here**.

_____

_____

3. **How much <u>Sexual Abuse</u> did you experience in your family or environment, or childhood, adulthood or life? Scale of 1 to 10** (*Being forced, manipulated, seduced, or shamed into giving or receiving sexual touch, conversations, things to watch, and/or intercourse etc., Limiting who we are as sexual individuals; IE. there is only way to be sexual, fantasize, design or format sexuality. Shaming around our sexuality. Our sexuality belongs to someone else. Lack of positive sexual/affectionate modeling).* **If you are willing, please explain here**.

_____

_____

4. **How much <u>Spiritual Abuse</u> did you experience in your family or environment, in childhood, or life? Scale of 1 to 10** (*Being forced, coerced, manipulated or shamed into believing or adhering to beliefs that were not authentic for your spirit and/or felt wrong to you and/or being beaten, punished, or ritual abuse. Anytime you are trained away from what is most authentic for you and your soul).* **If you are willing, please explain here**.

_____

_____

How was it to grow up in your family?

_____

_____

_____

Is there anything else we should know?

_____

_____

Thank you so much for your courage and commitment to your ecstatic wholeness!

Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

MANDATORY OFFICE POLICIES

1. As an outpatient therapist, we are not available 24 hours a day. Initials: _____
   In the case of an emergency, please call 911 or 211.

2. **Email and text messaging is used for making or cancelling appointments**. Emails and texts are not confidential and will not be used for therapeutic purposes! Initials: _____

3. Therapy and/ or coaching sessions can be done in our office, in a location client chooses, by video sessions on doxy.me, or the telephone. Initials: _____

4. Sessions are **53 minutes**. Please be on time! If you arrive late for an appointment, you are still charged the entire fee and/or copay. Initials: _____

5. **Payment** or **copay** is due at the beginning of each session, unless a payment plan is arranged. Initials: _____

6. **CANCELLATION POLICY:** If you are unable to make an appointment, give **24 hours**' **notice** by emailing info@sexandmagic.com OR your clinician. Initials: _____

   The first time a late cancellation or missed appointment occurs, you will be expected to pay **50% of the session fee** (the entire session fee – not just your copay). Initials: _____

   After the first late cancellation or missed appointment occurs, you will be expected to pay **100% of the session fee** in addition to your next appointment fee. Initials: _____

   FEES: Twice a year, March 1 and September 1, we have the right to adjust our therapeutic fees. Returned checks will be charged $30. Treatment will be ended if you fail to pay any charges accrued. Overdue accounts will be turned over to a collection agency, and you will be responsible for all reasonable associated costs. Initials: _____

   Case management services (such as writing letters; traveling to and from meetings, court appearances, etc.) have a surcharge of $150/Hour and is prorated for half-hour time periods and any part thereof. Initials: _____

7. **VOLUNTARY**: Unless otherwise noted, this process is voluntary.
   During treatment, provide us with **feedback** to ensure that you reach your goals. You may, at any time, withdraw from the process. Initials: _____

   While we hope to be of help to you, we cannot guarantee treatment outcome. We will make every effort to facilitate your goals or transfer you to another therapist. We will offer that same referral help if we find it necessary to end our work with you. Initials: _____

_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Guardian or Partner(s) Name(s)	Client(s) Signature(s)	Date Signed

Hartford, CT 06105
West Hartford, CT 06119

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

CONFIDENTIALITY/HIPAA STATEMENT

There are federal and state laws that protect your right to confidentiality about your treatment. Every effort is made to maintain the confidentiality of our clients.

In keeping with generally accepted standards of the practice and to ensure quality care, we consult with supervisors, interns, insurance companies, and other licensed professionals.

We must report the following exceptions:

1. DUTY TO WARN AND PROTECT: If a client reports an intention to harm him/herself or others.
2. ABUSE OF CHILDREN AND VULNERABLE ADULTS: If a client reports or suggests that a child or vulnerable adult is being or has recently been abused, or it is suspected he/she may be abused, or is in danger of being abused.
3. MINORS/GUARDIANSHIP: If a parent or legal guardian of a client under age 18 requests access to the client's records.
4. COURT ORDER/INSURANCE: If I am required to provide records or information by a court order or due to your insurance company.

Your signature below indicates that you understand and agree with all the statements in this agreement and that you consent to treatment with the clinician stated below.

_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Guardian or Partner(s) Name(s)	Guardian or Partner(s) Signature(s)	Date Signed
_____	_____	_____
Print Therapist Name	Therapist Signature	Date Signed