

## Real Life Solutions - Trauma Recovery

<b>CLIENT INFORMATION &amp; INFORMED CONSENT FORM</b>
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\_\_\_\_\_  
Client Name (Last, First)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Age

\_\_\_\_\_  
Gender

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Mailing Address (if different from above)

\_\_\_\_\_  
Primary Number to reach you

\_\_\_\_\_  
Secondary Phone

\_\_\_\_\_  
Email

Can messages be left on your answering machines? Yes \_\_\_\_ No \_\_\_\_

Marital status: Single\_\_ Married\_\_ Remarried\_\_ Single Parent\_\_ Widow(er)\_\_ Divorced Separated\_\_

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes\_\_ No\_\_  
If so, when? \_\_\_\_\_

Are you currently taking any medications? Yes\_\_ No\_\_ If yes, please list them  
\_\_\_\_\_

Religious/Spiritual affiliation \_\_\_\_\_ Level of Importance: High\_\_ Med\_\_ Low\_\_

Do you have children? Yes\_\_ No\_\_ If yes, what ages \_\_\_\_\_

Check any that currently apply to you, and circle those that are the most significant:

<input type="checkbox"/> Adjustments (new job, job loss, marriage or divorce, pet died, etc)	<input type="checkbox"/> Health (i.e. physical complaints, chronic pains)		
<input type="checkbox"/> Sadness or depressive symptoms	<input type="checkbox"/> Anxiety symptoms	<input type="checkbox"/> Anger or irritability	<input type="checkbox"/> Changes in mood
<input type="checkbox"/> Abuse	<input type="checkbox"/> Sleeping difficulties	<input type="checkbox"/> Obsessive thoughts	<input type="checkbox"/> Addictions
<input type="checkbox"/> Bad dreams/nightmares	<input type="checkbox"/> Eating difficulties	<input type="checkbox"/> Religious concerns	<input type="checkbox"/> Career decisions
<input type="checkbox"/> Personal growth	<input type="checkbox"/> Suicidal thinking	<input type="checkbox"/> Sexual concerns	<input type="checkbox"/> Worry or guilt
<input type="checkbox"/> Physical/Learning disability	<input type="checkbox"/> Chronic or terminal illness	<input type="checkbox"/> Relationship problem	<input type="checkbox"/> Other

Further description of above or any other concerns (optional):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of trauma, emotional, or behavioral difficulties? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of alcohol/drug/substance use, family violence, or criminal activity? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of chronic physical pains? (Somatization disorders, i.e. headaches, IBS, etc.) If yes, please describe  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of an emergency, contact:

\_\_\_\_\_  
(Name) Relationship to client Phone

Referral Source \_\_\_\_\_ May we thank referral? Yes \_\_\_ No \_\_\_\_\_

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***Office Policies and Procedures:***

**Finances/Cancellation:** All changes or cancellations must be made at least 24 hours prior to scheduled appointment, if not made within this time period, the client will be charged for the session as I am unable to offer the time to another client. The fee for a 50-minute session is \$165. For those who want a longer session, a 75-minute session is \$245. Fees may change periodically, with a 30 day notice provided. Payment is made in full at each session in the form of cash, credit card, or personal check. Real Life Solutions-T.R will attempt to bill insurance companies if you have coverage. We charge the standard fee per session because the insurance companies reimburse you. If the insurance company denies payment of any service, the client is responsible for payment of services. Phone & email time will be charged at the same rate as counseling sessions. Please note if your personal check bounces we will collect a \$25 return check charge.

**Confidentiality:** Information may be released to designated parties by written authorization of clients or legal guardians. Therapists are required to report suspected past or present abuse or neglect of children, dependent adults, and elders, to the appropriate authorities based on information provided by the client or collateral sources. Therapists are required to release information obtained from clients or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, spouses) to appropriate authorities to the extent to which such disclosure may help to avert danger to a psychotherapy client or to others, e.g.; imminent risk of suicide, homicide, or destruction of property that could endanger others. If a client is using confidentiality as a means of avoiding legal punishment, the therapist must break confidentiality because the therapist may not aid or abet committing a crime. Psychotherapists reserve the right to release financial information to a collections agency, attorney, or small claims court for delinquent client accounts.

**Emergencies:** The therapist may not be available 24 hours a day. If the client needs to speak with the therapist, the client is welcome to call during normal business hours. If the client cannot reach the therapist or has an emergency, the client can call 911 or the 24-hour Crisis Team at (888) 724-7240. When the therapist is out of town, he/she will provide the client with phone numbers of alternate sources of help.

I have read the above information, have asked questions as needed, and understand the issues related to the risks and benefits of psychotherapy, confidentiality, professional records, length of psychotherapy, fees, emergencies, and the obligations of clients. Based on my understanding of these issues, I agree to proceed with treatment.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

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**SOMATIC EXPERIENCING & TOUCH WORK INFORMED CONSENT**

Somatic Experiencing (SE) is a naturalistic approach to the resolution and healing of trauma developed by Dr. Peter Levine. SE releases traumatic shock (freeze) and supports the body's natural ability to regulate itself, which is key to transforming PTSD, chronic stress and the wounds of emotional and early developmental attachment trauma.

SE facilitates the completion of self-protective motor responses and the release of survival energy bound in the body, thus addressing the root cause of trauma symptoms, which can result in subtle or more intense experiences as the body discharges. This is approached by gently guiding clients to develop increasing tolerance for difficult bodily sensations and suppressed emotions, so as to not get overwhelmed.

- SE employs awareness of body sensation to help people "renegotiate" and heal rather than re-live or re-enact trauma.
- SE's guidance of the bodily "felt sense," allows the highly aroused or frozen survival energies to be safely experienced and gradually discharged.
- SE "titrates" your experience (breaks it down into small, incremental steps) so that you can remain embodied and present, rather than evoking a mindless catharsis.

SE does not require you to re-tell or re-live the traumatic event; It offers the opportunity to engage, complete, and resolve—in a slow and supported way—the body's instinctual fight, flight, freeze, and collapse responses. SE catalyzes corrective bodily experiences that contradict those of fear and helplessness and seeks to restore a sense of aliveness and pleasure. This resets the nervous system, restores inner balance, enhances resilience to stress, and increases people's vitality, equanimity, and capacity to actively engage in life.

- Note: Somatic Experiencing can be used with or without touch.

When appropriate and according to my clinical judgment, I may offer an intervention in which touch contact may increase your understanding of your body's non-verbal communication. The intention of SE Touch work is to support re-negotiation of trauma in the body and physiology. The SE/Touch skills work brings trauma recovery, self-regulation skills, and resilience. My 12 years of education and training in SE Touch work and the Kathy Kain Touch Skills trainings provides me with specific training in the application of touch interventions.

It is your responsibility to tell me when you are uncomfortable with any part of the treatment. If you have any questions about SE or Touch Skills I will do my best to answer your questions in full.

I consent to the use of SE and/or Touch work in therapy and will make any concerns known to you if they arise.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_