

# Cori A. Newlander, M.A., MFT

3231 Ocean Park Boulevard Suite 218, Santa Monica, CA 90405

(310) 466-1192

License: MFC41609

## GENERAL

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
# Street City State Zip

Phone \_\_\_\_\_ (Check the best # to call you on?)

Work: \_\_\_\_\_  Home: \_\_\_\_\_  Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship Status:  Single  *Legally Coupled* (Married or Domestic Partnered)

Cohabiting  Engaged  Separated or Divorced  Other \_\_\_\_\_

Who else lives in your home with you (continue on back if needed)?

Name \_\_\_\_\_

Relationship to you (spouse, child(ren), siblings, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact Information:

Name Phone Relationship to you

Who referred you to me? \_\_\_\_\_

## FAMILY OF ORIGIN HISTORY

Mother's Name: \_\_\_\_\_ Still living? \_\_\_\_\_ If not, year deceased: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Still living? \_\_\_\_\_ If not, year deceased: \_\_\_\_\_

Names and Ages of Siblings: \_\_\_\_\_

## AREAS OF CONCERN

What brings you to therapy at this time? (continue on back if needed)

\_\_\_\_\_

\_\_\_\_\_

Do you have any specific goals with regard to therapy? \_\_\_\_\_

\_\_\_\_\_

Do you have any particular concerns/fears with regard to therapy? \_\_\_\_\_

\_\_\_\_\_

**PSYCHOLOGICAL HISTORY**

Have you ever received psychotherapy before? \_\_\_\_\_

When and for how long? \_\_\_\_\_

What was the focus of treatment? \_\_\_\_\_

Where did you receive treatment? \_\_\_\_\_

Have you ever been hospitalized for emotional/psychiatric reasons? \_\_\_\_\_

When? \_\_\_\_\_ For how long? \_\_\_\_\_

Why were you hospitalized? \_\_\_\_\_

Where were you hospitalized? \_\_\_\_\_

Are you currently taking any prescription medications? \_\_\_\_\_

Prescribed by whom? \_\_\_\_\_

What are the medications (continue on back, if needed)?

_____ Medication	_____ For which symptoms	_____ Dosage	_____ For how long?
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_____ Medication	_____ For which symptoms	_____ Dosage	_____ For how long?
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_____ Medication	_____ For which symptoms	_____ Dosage	_____ For how long?
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Have you ever attempted suicide?  Yes  No When? \_\_\_\_\_

Describe the circumstances that led to that attempt: \_\_\_\_\_

\_\_\_\_\_

Are you currently having any suicidal or self-harming thoughts? Please describe: \_\_\_\_\_

\_\_\_\_\_

Were you ever been subjected to verbal, physical, emotional or sexual abuse? Please describe:

\_\_\_\_\_

Have you ever been a victim of a violent crime? Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

Have you ever been diagnosed with a serious illness? Please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you have any medical conditions that may affect your mental health treatment? \_\_\_\_\_  
\_\_\_\_\_

Please describe your overall health today: \_\_\_\_\_

Are you physically active? Please describe: \_\_\_\_\_

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related conditions? Please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Are you now or have you ever been in a 12-step program? Please describe \_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Y  N How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol?  Y  N On average, how many drinks do you consume per week? \_\_\_\_\_

Do you currently use illegal drugs?  Y  N Have you ever used illegal drugs?  Y  N

Please describe your use (substance, frequency, duration, amount) \_\_\_\_\_  
\_\_\_\_\_

**OTHER INFORMATION**

Please describe your spiritual identity/orientation: \_\_\_\_\_

Please describe your interests/hobbies: \_\_\_\_\_

Are you now or have you ever been involved in a lawsuit? \_\_\_\_\_

What were the circumstances around the lawsuit? \_\_\_\_\_

Please feel free to include any other information you would like me to know about you:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## CLIENT INFORMATION

As a **Marriage and Family Therapist**, I am governed by regulations and laws of the State of California, as well as by a code of ethics of my profession. It is important for you, the client, to be aware of standard procedures of psychotherapy that may affect you.

**Limits of Confidentiality:** All therapy sessions between a Psychotherapist and a client are confidential except under certain legally-defined situations:

- a) If you share something with me that leads me to believe that you are at risk of harming yourself/committing suicide, I will break the agreement of confidentiality to ensure your safety;
- b) If you share something with me that leads me to believe that a child, elder or dependent-adult is being abused, I am required by law to report the abuse to the proper authorities;
- c) If you share something with me that leads me to believe that you will harm another person or their property, I am required by law to contact both the police and the intended victim.

**Appointments:** Therapy sessions are 50 minutes in length. If it is necessary to cancel or reschedule an existing weekly appointment, please notify me **48 hours** in advance of your appointment time, otherwise you will be charged for the missed session.

**Payment and Fees:** Payment is due each week and can be paid by check or in cash. I do not take credit cards. Let me know if you need a receipt, and I can provide monthly or quarterly receipts upon request. If you have appropriate insurance coverage, you will need to work directly with your insurance company to collect reimbursement. Please make checks payable to **Cori A. Newlander, MFT**

**E-mail Policy:** Although e-mail is a fast and easy way to communicate, I am not legally permitted to discuss your care and treatment through e-mail. For that reason, please understand that if you e-mail me, I may wait to communicate back with you until we are in session. In addition, any requested forms that reference your name and/or contact information (insurance, releases, etc.) will be mailed to you through the post office, rather than e-mail. My goal is to protect your confidentiality.

I have read and understood the information above and I agree to enter into therapy under these conditions.

\_\_\_\_\_  
Client Name

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Cori A. Newlander, M.A. MFT  
MFC41609

\_\_\_\_\_  
Date