CONFIDENTIAL INFORMATION FORM: ADULTS

Date: _____

Name: _____ DOB : _____

Home Address: _____ Driver's License:_____
City, State: _____ Zipcode: _____
Employer: _____ Occupation: _____
Address: _____ SS#: _____

Phone: Home: _____ OK to leave message ( )
Work: _____ OK to leave message ( )
Cell: _____ OK to leave message ( )
Email: _____ OK to email ( )

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Living Together ( ) Divorced

Partner Name: _____ DOB: _____

Employer: _____ Occupation: _____
Address: _____ SS#: _____

_____

Phone: Home: _____ OK to leave message ( )
Work: _____ OK to leave message ( )
Other: _____ OK to leave message ( )

Children / Others Living With You: DOB / Age: School / Occupation: Grade:

Name: _____ _____ _____ _____

Name: _____ _____ _____ _____

Name: _____ _____ _____ _____

Emergency Contact: _____ Relationship:_____

Contact's Phone Numbers: _____

Referred by:_____ OK to send Thank You letter ( ) _____ Initials

Address: _____

Informed Consent

Everyone participating in therapy is entitled to *confidentiality* with certain exceptions. These include situations where a client presents a danger to him/herself, an expressed danger to others, or where the therapist suspects that abuse of a child under the age of 18, an elder over 65 or a dependent adult is occurring or has occurred.

Therapy appointments are made in advance and this reserves my time for you. If you need to cancel, please do so with a minimum of two (2) business days' notice so we may schedule someone else in that slot. *If you do not give 2 business days' notice to cancel, you will be charged your full fee for the missed appointment.* (Example: to cancel a 10 am Monday appt, call by 10 am on Thursday the week prior; to cancel a Wednesday noon appt, call Monday by noon that week.)

I am not on call for emergencies. To *contact me between sessions*, please call and leave a message on my confidential voice mail: 949-929-5470 (on business card). Your call will be returned as soon as practically possible within one business day. If there is a life-threatening emergency, please call 911 immediately.

You will be charged a *$25.00 service fee for each returned check*. Payment of both the usual fee and service fee must be received before therapy will continue.

If you wish to have *insurance* pay for your therapy, I require payment at the time of service; however, I will supply you with a super-bill insurance claim form for you to submit to your insurance carrier. In accordance with your policy, the insurance company will determine coverage and make any reimbursements for services rendered directly to you.

Treatment Agreements:

I agree to enter therapy with Amy St. Hilaire, MFT.
I understand that the initial intake is a 115 minutes and agree to pay $360.00 and subsequent visits are customarily 85-minutes in length for which I will pay $270.00 at the start of each session, payable by cash, check, or MasterCard/Visa. (When you use a credit card, a 4% transaction fee will be added to the total.)
I understand that my therapist is a sole-proprietor and works in her own independent private practice. Although she shares space with others in the Center, I understand that no one is legally connected to or responsible for the work of others in the Center.
I have read and understand my rights, the parameters of comprehensive energy psychotherapy, the office policies, the limits of confidentiality and these conditions of our work together. _____

_____ Initial here

Name of Client or Guardian

_____

Signature of Client or Guardian

_____

Date

_____

Name of Clinician

_____

Signature of Clinician

_____

Date

Informed Consent for Comprehensive Energy Psychotherapy

Comprehensive Energy Psychotherapy (CEP) constitutes a large family of therapeutic approaches that are grounded in mind/body theory. CEP modalities include work with three major interacting systems: 1) Pathways (meridians and related acupoints); 2) Centers (chakras); and 3) the Biofield (aura). While there are many approaches to working with each of these three aspects independently, Comprehensive Energy Psychology embraces all three interactive energy systems to enhance outcomes for selected clients.

CEP practitioners seek to follow the client's own innate wisdom about which modality will work best for them. This can be done through the process of muscle testing—a form of applied kinesiology. This process is a way to "tune into" the body's often unconscious wisdom to find answers to questions about how to proceed throughout CEP sessions. This may involve the CEP practitioner asking you a question and then applying light pressure to your arm/s to see where the arm muscle holds up to the pressure indicating a "yes" response in most cases and where the muscle naturally relaxes indicating a "no" response in most cases with a few exceptions known as psychological reversal or neurological disorganization which are imbalances in the body's energy field that can usually be balanced in-session or through "homework".

Initial _____ I consent to the use of muscle testing to guide our sessions and to the discussion and demonstration of how to correct for psychological reversals or neurological disorganizations that block accurate testing.

-OR-

Initial _____ I prefer to exercise my right to use self-muscle testing which would mean that my CEP practitioner does not touch my arms or body and I request/do not request training in how to self-test to tune into my innate wisdom.

_____ I understand that while many psychotherapists and clients are reporting success with these techniques, these methods are innovative and new. Rigorous double-blind studies have not yet been done and we cannot guarantee results or make any claims for specific client populations. CEP treatments are still considered experimental and I have the right to know about and use more traditional treatments for my particular presenting problem.

_____ I understand that while some clients experience significant symptom relief in a single treatment, additional treatments may be necessary and that complex problems and situations are likely to require treatment for each of the various aspects of the whole problem. Furthermore, I understand that relief from a symptom or a serious problem may not in itself provide understanding of the role the problem has played in my life or the coping skills and communication tools I may need in order to move on and reach my personal goals. I agree that I will continue with this work to review and discuss these issues as long as it proves helpful to me.

Initial

_____ I understand I have the right to terminate therapy with my CEP practitioner at any time without additional financial, legal or moral obligations other than those I have already incurred. If this is the case, my practitioner will provide me with the names of other qualified professionals whose services I might prefer.

_____ I have read the attached materials on Healing from the Body Level Up (HBLU) and have had an opportunity to ask any questions and to discuss any concerns I may have.

_____ I have the right to request other reading material on:
Comprehensive Energy Psychology www.energypsych.org ,
Thought Field Therapy www.tftrx.com ,
Emotional Freedom Technique www.emofree.com ,
Healing From the Body Level Up www.hblu.org ,
Seemorg Matrix www.seemorgmatrix.org ,
Tapas Acupressure Technique www.tat-intl.com
muscle testing www.worldtrans.org/TP/TP2/TP2A-67.HTML or other modalities.

_____ I further agree to contact my CEP practitioner, _____, should I experience any difficulty or concern after having a CEP session. I understand that s/he will return my call as soon as is practically possible within one business day.

_____ I understand that I may experience "a feeling of difference" as my body/mind/soul adjusts to this change and integrates the implications, i.e., if a fear of flying or public speaking is removed, there are implications to these new freedoms that may require a period of integration and readjustment. I understand that if I experience any feelings of fogginess, spaciness, trance or fatigue after CEP work, this indicates that I am still processing the healing and the integration of the work. I can finish up the process in minutes by doing a process called Unwinding Frontal/Occipital Holding. Instructions: Place one had across your forehead and one hand across the back of your head and allow your head to move however it wants to move while concentrating on the unfocused feeling. Your head will stop moving when the process is complete and you will feel like you are back in focus. You can then write down anything else you realized or learned and bring that in to your next session. You may also just need to sleep/dream on it and that will integrate the healing over a few hours or days.

_____ _____

Printed Name of Client or Guardian Date

_____ _____

Signature of Client or Guardian Signature of Practitioner

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

If the client threatens suicide.*
If the client threatens to harm another person.*
If I have reason to suspect that a minor is being abused: including, but not limited to physical abuse, sexual abuse and unjustifiable cruelty or unreasonable punishment.*
If I have reason to suspect that an elderly person over 65 years of age or a dependent adult is being abused.*
If I am ordered by the courts to break confidentiality to comply with legal requirements.
If I consult with other marriage & family therapists, social workers or psychologists in order to provide you with the best care and service.
If I have a written release from you, authorizing me to speak with a party you designate such as an insurance company representative, doctor, other healthcare provider, school or family member.

* State law mandates that mental health professionals need to consult with social services to report these situations to the appropriate agency designated to receive such report.

All other communications between therapist and client will be deemed confidential under the laws of the state.

Having read and understood the above, I agree to these limits of confidentiality.

Name of Client or Guardian	Date
Signature of Client or Guardian	Signature of Clinician

Mind~Body~Spirit & Goals Inventory

Mind
Please list all the tools/strengths you use to cope with stress and maintain balance in your life (e.g. yoga, exercise, positive self-talk, affirmations, meditation, journaling, bodywork, support groups, etc.):

Are you aware of any limiting beliefs that are holding you back? Limiting beliefs are one-sentence statements we believe on some level are true, even though another part of us "knows better." e.g. "I'm not worthy" or "I'm stupid"

Please identify your greatest fears. It could be phobias or fears of dying, being alone, not fulfilling your potential

Body
Please describe your childhood medical history: including gestation, birth, vaccinations, illnesses, broken limbs, etc.

Please describe your adult medical history: illnesses, diseases or syndromes (e.g. cancer, diabetes, lupus, IBS, fibromyalgia, chronic fatigues, etc.) surgeries, broken bones, dental problems, recurring physical complaints, (e.g. migraines, asthma, lower back pain, foot pain, recurrent sinus infections or strept throat, allergies, etc.)

Please list any addictions you have now or have struggled with in the past (e.g. alcohol/other drugs, gambling, shopping, sex, anorexia/bulimia, etc.)

Please list the ways you stimulate yourself or create excitement in your life (e.g. shopping, reading, sex, sugar, caffeine, partying, etc.)

Spirit
Briefly describe your religious or spiritual upbringing—ie, that which you were exposed to from your parents/the people who raised you or your teachers/school, or any other significant person or event in your life:

Please describe your current religious or spiritual beliefs and/or practices *or* describe how you connect with the "more than"—that which is *more than* you, the bigger picture, nature, Spirit, God?

Are there any events in your life you feel separated you from God/Higher Power?

Relationships

What was each parent like when you were a child?

What was your relationship with each parent growing up and now?

What was your parent's relationship with each other when you lived with them?

Please describe any other significant relationships with other family members or friends from childhood:

Please list all adult traumatic events and issues; relational, psychological and spiritual:

Goals

Please list 5 of your most significant accomplishments in your life:

1.

2.

3.

4.

5.

Please list 5 goals you have for yourself/your relationship for which you are seeking consultation at this time:

1.

2.

3.

4.

5.

Please list 5 strengths or tools that help you reach your goals:

1.

2.

3.

4.

5.

Please list 5 ways you sabotage yourself and your goals:

1.

2.

3.

4.

5.