Jackson
Marriage and Family
Counseling Services

1629 K Street NW Suite 300 Washington DC 20006 202.809-1174 www.jacksonmarriageandfamily.com

Limits of the Therapy Relationship: What Clients Should Know

Psychotherapy is a professional service I can provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client *only*. If we were to interact in any other ways, we would then have a "dual relationship," which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

I want to explain why having a dual relationship is not a good idea. Dual relationships can set up conflicts between my own (the therapist's) interests and your (the client's) best interests, and then your interests might not be put first. In order to offer all my clients the best care, my judgment needs to be unselfish and professional.

Because I am your therapist, dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts.
- I cannot provide therapy to people I used to know socially, or to former business contacts.
- I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you, or trade or barter your services (things like tutoring, repairing, child care, etc.) or goods for therapy.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. As your therapist, I cannot be your friend. Friends may see you only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their clients secret. Therefore, I may ignore you when we meet in a public place, and I must decline to attend your family's gatherings if you invite me. Lastly, when our therapy is completed, I will not be able to be a friend to you like your other friends.

In sum, my duty as therapist is to care for you and my other clients, but *only* in the professional role of therapist. Please note any questions or concerns on the back of this page so we can discuss them.

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Client Information Form I

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

_____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

_____

C. Religious and racial/ethnic identification

Religious denomination/affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist

❑ Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____

Or other similar way you identity yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

(cont.)

_____

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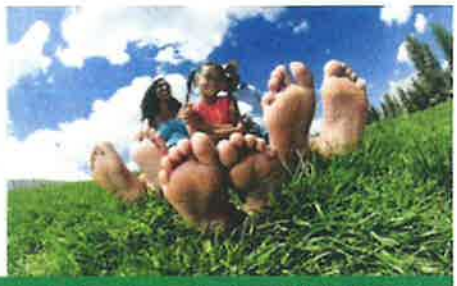

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Client Information Form 2

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
   ❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

(cont.)

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

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Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, supplements, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

(cont.)

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Chemical Use Survey

Name: _____ Date: _____

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/or other chemicals that can affect you psychologically. So please answer these questions fully.

A. What have you used?

1. Think about any and all chemicals you have used, and indicate how much you used (amount) and how often. Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	Age started	Last use	Over the last 30 days		See question 3, below
			Amount and how often	Effects/consequences	
Caffeine					
Tobacco (smoked or chewed)					
Alcohol					
Marijuana/THC					
Cocaine/crack (snorted, injected, or smoked)					
Inhalants ("Huffing")					
LSD					
Prescribed pills					
Others: Specify					

2. Write "P" above next to your primary drug of choice.
3. For each chemical you currently use, what causes you to stop? Enter one or more of these letters in the last column above: A = The money runs out. B = I use up my supply. C = Personal choice. D = Unconsciousness. E = Achieved my purpose. F = Other reasons: _____
4. What are or were your sources of money for buying the chemicals you have used? _____

_____

B. Which of these have you had? ❑ Blackouts ❑ Withdrawal symptoms ❑ Cravings ❑ Overdoses

❑ Detoxification in a hospital ❑ Tolerance ("Could not get high no matter how much I took")

❑ Preoccupation (spent lots of time finding and using chemicals) ❑ Failed attempts to cut down or control use

❑ Other problems: _____

(cont.)

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Agreement to Pay for Professional Services

I request that the therapist named below provide professional services to me or to _____, who is my _____, and I agree to pay this therapist's fee of $_____ per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I have also read this therapist's "Information for Clients" brochure and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

When life challenges require a different perspective