Dr John Drimmer, Psy.D
179 South Barrington Place ~ Suite B
Los Angeles CA 90049
john@positivepsychologyLA.com www.PositivePsychologyLA.com
Phone: 310 499 5678

Welcome to my practice! The following is provided to help you become acquainted with the way I work. Please take time to read it carefully. I will gladly discuss any of these items with you.

- Effective psychotherapy requires a good match between client and therapist. During our first session or two we will determine if I'm a good choice of therapist for you. If not, I will refer you to a therapist I believe can serve you better than I.
- Because I divide my time between private practice and teaching workshops out of town, I'm not always available for crisis management. Clients who have frequent crises, or who need a lot of between-session therapist support, will be referred to therapists who are more available for that level of care.
- I assume you wish to begin therapy because you desire certain changes in your life. I will do my best to help you achieve your goals, but I cannot guarantee any particular result. You are likely to gain the most benefit from counseling if you are committed to the process and attend regularly.
- Since biological factors can contribute to unwanted psychological distress, I may ask you about your health and diet. In some cases medical assessment and intervention is helpful and/or necessary.
- From time to time I may ask you to fill out various questionnaires. Please fill these out as best you can, it helps me learn important details about you without taking up extra session time.

Session Fees

- Payment for therapy will be due at the end of each session.
- I do not have a secretary to collect your fees, so please come prepared to pay with check or cash at the end of our session.

Additional Fees

- **Short-Notice Cancellation Fee:** Appointment cancellations made less than 48 hours before the scheduled appointment will be subject to the total session charge.
- If a check of yours is returned by the bank for insufficient funds, you will be responsible for reimbursing any bank fees charged to my account for your returned check.

Scheduling

- I will make every effort to schedule your appointments at times that are convenient for you.
- Clients typically schedule 50-minute, 80-minute, or 105-minutes sessions – one per week. Longer sessions that are scheduled close together tend to result in the most efficient outcome.
- I do not have a secretary to schedule my appointments. If possible, please come prepared to schedule your next appointment at the end of each session.

Confidentiality

Except for certain situations, matters shared in counseling sessions will not be disclosed to anyone without your written permission. There are some exceptions to this:

- Therapists are legally required to report suspected abuse, neglect, or exploitation of a child, an elderly person, or a disabled person to the appropriate agency.
- Therapists have a legal and ethical obligation to warn appropriate authorities, family members, etc., when a client is seriously considering harming him/herself or others.
- Client case notes and records may be subject to subpoena when a client is involved in civil or criminal legal proceedings.

Consent for Therapy

I, _____, give permission to Dr John Drimmer, PsyD, (License PSY228866), to provide psychological treatment, counseling and assessment. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. By my signature I am affirming that the contents of this document have been satisfactorily explained to me.

Signature: _____ Date: _____

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Phone: 310 499 5678

Name: Date:

Street: City: Zip:

Home Phone: Cell Phone:

email:

Occupation: Employer

Sex: *Male* *Female* Date of Birth: Age:

Marital status (circle all that apply): *Single* *Engaged* *Living together* *Married* *Separated* *Divorced* *Widowed*

Name of Partner:

Referred by:

If you found us on the net, through which site?_____

Names of Siblings	Age	Gender	Quality of Relationship?
		M F	
		M F	
		M F	
		M F	
		M F	

Names of Children	Age	Gender	Living w/ you?	Comments:
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	

Please briefly explain to me what brought you to seek counseling at this time:

Have you ever seen a mental health professional before? *Yes* *No*
If yes, please tell me when it was and why you went.

Also: were you happy with it? Can you tell us a little about why you were, or were not

How often do you get 20 minutes or more of exercise? _____

Do you practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? *Yes* *No*

If yes, what and how often? _____

How many caffeinated drinks (coffee, sodas, tea, hot chocolate) do you usually drink per day? _____

How much alcohol do you usually drink? _____

Do you smoke? How much? _____

Do you use "recreational" drugs? *Yes* *No* If yes, what and how often? _____

_____

Do you take vitamins and/or herbal remedies? *Yes* *No* If yes, what and how often? _____

_____

Which category best describes your diet?

- ❑ *Very Healthy* (Lots of fresh fruits/vegetables/whole grains, and few sweets/fatty foods.)
- ❑ Between *Moderately Healthy* & *Very Healthy*
- ❑ *Moderately Healthy* (Some fresh fruits/vegetables/whole grains, and some sweets/fatty foods.)
- ❑ Between *Unhealthy* & *Moderately Healthy*
- ❑ *Unhealthy* (Few fresh fruits/vegetables/whole grains, and lots of sweets/fatty foods.)

Who is your primary physician? Phone #:

Please list any troublesome or significant medical conditions you may have.

Please list your current medications (Prescription & Non-Prescription):

Drug	Dose	Frequency	When Started	For what symptom(s)	Prescribing Doctor

Who should be notified in case of emergency?

Name: Relationship:

Home Phone: Work Phone: Pager:

Name **Date**

Symptom Frequency Scales

How often have you experienced the following symptoms over the last two weeks?
(all responses are strictly confidential.)

Depression	***Not at all***				***Sometimes***						***All the time***	✓ Drug Related
Feelings of sadness	0	1	2	3	4	5	6	7	8	9	10	
Difficulty falling asleep and/or staying asleep	0	1	2	3	4	5	6	7	8	9	10	
Desire to spend a lot of time sleeping	0	1	2	3	4	5	6	7	8	9	10	
Fatigue or loss of energy	0	1	2	3	4	5	6	7	8	9	10	
No interest in formerly pleasant activities	0	1	2	3	4	5	6	7	8	9	10	
Feelings of worthlessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of hopelessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of excessive and/or inappropriate guilt	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of being punished	0	1	2	3	4	5	6	7	8	9	10	
Impaired ability to concentrate	0	1	2	3	4	5	6	7	8	9	10	
Indecisiveness	0	1	2	3	4	5	6	7	8	9	10	
Excessive appetite OR poor appetite	0	1	2	3	4	5	6	7	8	9	10	
Feelings of restlessness	0	1	2	3	4	5	6	7	8	9	10	
Sense of moving slowly	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of death	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of suicide	0	1	2	3	4	5	6	7	8	9	10	
Unplanned weight gain OR weight loss	NO	YES	If yes, how much?									

Anxiety	***Not at all***				***Sometimes***						***All the time***	✓ Drug Related
Inability to relax	0	1	2	3	4	5	6	7	8	9	10	
Nervousness	0	1	2	3	4	5	6	7	8	9	10	
Numbness or tingling	0	1	2	3	4	5	6	7	8	9	10	
Heart pounding or racing	0	1	2	3	4	5	6	7	8	9	10	
Indigestion and/or discomfort in abdomen	0	1	2	3	4	5	6	7	8	9	10	
Feelings of choking	0	1	2	3	4	5	6	7	8	9	10	
Shaky	0	1	2	3	4	5	6	7	8	9	10	
Scared	0	1	2	3	4	5	6	7	8	9	10	
Difficulty breathing	0	1	2	3	4	5	6	7	8	9	10	
Racing thoughts	0	1	2	3	4	5	6	7	8	9	10	
Sweating (not due to heat)	0	1	2	3	4	5	6	7	8	9	10	
Dizziness or lightheaded	0	1	2	3	4	5	6	7	8	9	10	
Fear of the worst happening	0	1	2	3	4	5	6	7	8	9	10	
Fear of losing control	0	1	2	3	4	5	6	7	8	9	10	
Fear of dying	0	1	2	3	4	5	6	7	8	9	10	