INFORMED CONSENT:PARENT.GUARDIAN INFORMED CONSENT

Consent:
Your signatures and initials below indicate that you consent to enter therapy through an informed decision. This document will serve as the contract between the client and the Olson Clinic. This document outlines clinic procedures, client/student therapist relationship and serves as a guideline for our working relationship.

The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) is a teaching-clinic, and therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved Supervisors/Supervisor candidates. In order to provide the best services possible, sessions are subject to video recording or observation by clinic Supervisors or other students in the Olson Clinic. Supervisor/Clinical Director may deem it important or necessary to be part of/join/conduct sessions at the Olson Clinic. All Student Therapists and faculty Supervisors are required to uphold the Code of Ethics of the American Association of Marriage and Family Therapists and Iowa Law. Copies of these codes are available upon request.

The Olson Clinic cannot make recommendations on or conduct evaluations for custody of children. The Olson Clinic cannot provide primary treatment for active substance use and abuse. The Olson Clinic cannot see clients that are experiencing active psychosis.

_____ (initials) I understand therapy sessions are video and audio recorded for review at the Olson Clinic, and in signing this informed consent, I agree to allow The Olson Clinic to record my sessions

_____ (initial) I understand that The Olson Clinic is not a crisis center and is not staffed or qualified as one. I agree that if I am in crisis or assessed to be in crisis, the clinic staff and/or Student Therapist will refer me to or call crisis management on my behalf, which could include 911, police and/or mobile crisis

_____ (initial) I agree to enter the therapy process aware that there may be potential for emotional strains, stresses, and life changes as a result of therapy. I agree that The Olson Clinic does not guarantee any particular results or outcome from the therapy process.

_____ (initial) When I do decide to terminate therapy, I agree to discuss this decision in a regular session with my therapist. Due to the nature of this clinic, if a file goes 30 days with no activity, it will be closed. I am still responsible for all unpaid fees at the time of closure. In the event that I wish to attend therapy again in the future, the file may be reopened by calling (319-368-6493).

_____ (initial) I understand that "The Good Faith Estimate" which is given to me during intake for my personal records includes personal health information. During the course of treatment, there may also be other documents provided to me by my therapist that include personal health information. When such document(s) are given to me, I understand that I am responsible for safeguarding their contents as I see fit. I will not hold the Olson Clinic and/or its staff members/providers liable for any information that may be seen by another party on forms and documents from the Olson Clinic that are in my possession.

Cancellations:
_____ (initial) 24-hour notice is required for all cancellations. If appropriate notice is not given, 50% of your session fee will be charged to your file. After three cancellations with less than 24-hours' notice, your file may be closed. In the case of a returned check, a $25 fee will be added to the account.

HIPAA:

_____ (initial) I acknowledge I have received, have read (or had read to me), and understand the contents of The Olson Clinic Notice of Private Practices. I fully understand its contents, and if I had any questions regarding this document, they have been fully answered.

All student therapists and faculty supervisors are required to hold information about sessions and clients in confidence. **The Olson Clinic will not disclose client information without the expressed written consent of every member involved in treatment. This means that if more than one person is involved in treatment, all individuals associated with that treatment must sign a release of information before any information will be provided for use outside the clinic. This applies to all session types: in-person, telehealth, or phone.**

The exceptions to confidentiality policies are the following circumstances:

1. _____ (initials) If there is clear and imminent danger to you or others, in which case either clinic may be required to inform the responsible authorities or warn the identified victim. In this event, the therapist will inform you of their responsibilities and actions.

2. _____ (initials) In situations of suspected physical, emotional, or sexual abuse of a child, elderly or dependent adult abuse, therapists are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation, you would be informed of the therapist's responsibilities and actions.

3. _____ (initials) The clinic maintains records of treatment, diagnosis, assessment, and treatment planning in order to collaborate with clinic staff and supervisors, and to better inform treatment and assess its effectiveness. You may request restrictions as to how your case information may be used or shared among clinic staff; however, the Olson Clinic and MMUCC are not required to agree to those restrictions.

4. _____ (initials) As the Olson Clinic is a training facility, you agree that staff, clinical supervisors, and other therapists may have access to confidential information for the purpose of clinical effectiveness.

5. _____ (initials) Some litigation may require the release of records even without the client's authorization. Student therapists will not typically testify in court (unless mandated) as this is outside of their scope of training, and they are not qualified to do so.

6. _____ (initials) If you have tested positive for the Coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits.

Research:
_____ (initial) I am aware the Olson MFT Clinic uses all client paperwork and video/audio recordings for academic research purposes. **No identifying information is used for this research, including name, date of birth, address, etc.** Each client will be randomly assigned a number to ensure confidentiality further, and all paperwork and recordings will be kept in a safe and secure location within the clinic. When needed, video recordings will be coded for research purposes, but no raw footage will be used. If at any point, you would like to withdraw your information from the data that is being collected, you are able to do so by letting your therapist or the front office staff know. There are no known risks associated with the collection of this data.

SESSIONS

Sessions will be conducted in either in-person or telehealth/phone sessions. The session type will be determined by client and student therapist. If there is a resurgence of the pandemic or if other health concerns arise, however, student therapist, or supervisor/clinical director, may require that we meet via telehealth only. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if the student therapist, or supervisor/clinical director, believes it is necessary, the Olson Clinic may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision as long as it is feasible and clinically appropriate.

Depending on session type, the client will adhere to the following guidelines:

IN-PERSON SESSIONS GUIDELINES

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Mount Mercy University (MMU) and The Olson Clinic have put in place preventative measures to reduce the spread of COVID-19; however, MMU, and/or The Olson Clinic cannot guarantee that you, your partner, or your child(ren) will not become infected with COVID-19 as a result of entering MMU, and/or The Olson Clinic. Further, attending in-person sessions could increase your risk, your partner's risk, and your child(ren)'s risk of contracting COVID-19.

RISKS OF OPTING FOR IN-PERSON SERVICES

_____ (initial) I acknowledge the contagious nature of COVID-19. I voluntarily assume the risk that myself, my partner, and my child(ren), and I may be exposed to or infected by COVID-19 by attending in-person sessions and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

_____ (initial) By initialing, you understand that MMU, and/or The Olson Clinic have zero control over whether or not those other individuals are taking action to minimize exposure or protect you from COVID 19, and you will not hold MMU, The Olson Clinic and/or the personally liable of actions/inactions other individuals have/have not taken to limit the spread of infection.

_____ (initial) I understand that the risk of becoming exposed to or infected by COVID-19 at MMU, and/or The Olson Clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to, MMU, and/or The Olson Clinic staff/employees, faculty, volunteers, students, and other professionals are working in the building, practicum students, or other clients/persons who were in the building.

_____ (initial) I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself, my partner, or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I, my partner, or my child(ren) may experience or incur in connection with my, my partners, or child(ren)'s attendance at MMU, and The Olson Clinic ("Claims").

_____ (initial) On my behalf, and on behalf of my partner, and child(ren), I hereby release, covenant not to sue, discharge, and hold harmless MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

_____ (initial) I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person therapy sessions. I understand and agree to take the risk of exposure to the Coronavirus.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:

Wearing a Mask:

_____ (initial) When required by University/Clinic policy you will wear a mask at all appointments and while inside the CRST Graduate Center/Olson Clinic.

Before a Session:

_____ (initial) You will only keep your in-person appointment if you are symptom-free for at least 24 hours.

_____ (initial) You will take your temperature before coming to each appointment. If it is elevated (100.4 Fahrenheit or more), or if you have other symptoms of the Coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged our normal cancellation fee.

During a Session:

_____ (initial) You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

_____ (initial) You will have your temperature taken by front desk and record temp. on COVID Screener.

_____ (initial) You will fill out a COVID Screener at every session; these will be provided by the front desk.

_____ (initial) You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.

_____ (initial) You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands/hugs) with your student therapist and staff.

_____ (initial) If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.

_____ (initial) You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

Outside a Session:

_____ (initial) You will take steps between appointments to minimize your exposure to COVID.

_____ (initial) If you have a job that exposes you to other people who are infected, you will immediately let us know.

_____ (initial) If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let us know.

_____ (initial) If a resident of your home tests positive for the infection, you will immediately let us know and we will then begin/resume treatment via telehealth.

_____ (initial) The Olson Clinic may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Our Commitment to Minimize Exposure

MMU and The Olson Clinic have taken steps to reduce the risk of spreading the Coronavirus within the clinic. We have posted our efforts on the Olson Clinic website and in the office. Please let your student therapist know if you have questions about these efforts.

If You or Your Student Therapist is Sick

You understand that your student therapist is committed to keeping you, themselves, and all of our families safe from the spread of this virus. If you show up for an appointment and we believe that you have a fever or other symptoms or believe if you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If your student therapist, other students, faculty, or staff, that you have come into contact with, test positive for the Coronavirus, we will notify you so that you can take appropriate precautions.

TELEHEALTH GUIDELINES

Telemental-health involves the use of electronic communications to enable health care providers to share individual patient therapeutic information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient therapeutic records; Therapeutic images; Live two-way audio and video; Output date from therapeutic devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. In other words, Zoom Business states that their system is HIPAA Compliant.

Your therapist will contact you with an appointment date and time via email. Your name, date and time of appointment is considered Protected Health Information (PHI). Due to the risk inherent in HIPAA compliance with the use of any telemental-health or technology devices, please consider the following:

The 2013 HHS HIPPA Omnibus Rule:

"If individuals are notified of the risks and still prefer unencrypted email, **the individual has the right to receive protected health information in that way**, and covered entities are not responsible for unauthorized access of PHI while in transmission to the individual, based on the individual's request. Further, covered

entities are not responsible for safeguarding information once delivered to the individual" (U.S. Department of Health and Human Services, 2013). You should also be aware that any emails I receive from you and any responses that I send to you become a part of your legal record.

I understand & agree to each of the following statements regarding telehealth:

_____ **(initial)** I understand the risks of receiving an email for my appointment through Zoom and/or KASA (medical records system) and I still prefer to receive these.

_____ **(initial)** I understand the risks of receiving communicating with my therapist about appointment times via email and I still prefer to receive these.

_____ **(initial)** I understand that all electronic communication is a part of my legal-medical record.

_____ **(initial)** I understand that I have to be physically located in the State of Iowa at the time of my session. If I am in another state, I understand I must reschedule the session.

_____ **(initial)** I understand I am not to be in the act of driving. If I am, I understand the session will be rescheduled.

_____ **(initial)** I understand that in very rare instances, security protocols could fail, causing a breach of privacy of personal therapeutic information.

_____ **(initial)** I also understand that the Olson MFT Clinic utilizes the below suicidality protocol while doing telehealth sessions:

- I understand I will be asked EVERY session before starting the session if I have any suicidal thoughts, ideation, plan or intention.
- I understand, if I say "yes" to anything more than passive ideation, I will be required to call Foundation 2 crisis line (319-362-2174) so that I can be fully assessed for safety.
- I understand I cannot continue sessions without confirmation of safety.
- I understand if I tell my therapist I have intentions or plans to kill or hurt myself or others, my therapist will call mobile crisis, 911 and/or police.

_____ **(initial)** By agreeing to Telehealth (video) session via HIPAA compliant Zoom, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

PHONE

_____ **(initial)** Phone sessions are *not* HIPAA compliant due to the nature of phones. Your student therapist will do everything they can to maintain your confidentiality in a phone session but cannot promise full confidentiality.

_____ **(initial)** By agreeing to sessions via phone, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

FEES

Fees for Service [Student Therapist will fill out]: $_____ /session

In-person, telehealth or phone session fee are billed at the same rate. Fees are determined on a sliding fee scale below and are due at the time of the session.

Sliding Fee Schedule – Based on 2021 Federal Poverty Guidelines					
Family Size	Minimum	25% Pay	50% Pay	75% Pay	100% Pay
Income Level	100%	133%	166%	200%	233%+
1	$12,880	$17,130	$21,381	$25,760	$30,010
2	$17,420	$23,169	$28,917	$34,840	$40,589
3	$21,960	$29,207	$36,454	$43,920	$51,167
4	$26,500	$35,245	$43,990	$53,000	$61,745
5	$31,040	$41,283	$51,526	$62,080	$72,323
6	$35,580	$47,321	$59,063	$71,160	$82,901
7	$40,120	$53,360	$66,599	$80,240	$93,480
8	$44,600	$59,318	$74,036	$89,200	$103,918
Fee	$10.00	$15.00	$20.00	$25.00	$30.00

By signing below, I agree to the guidelines outlined in regard to General Clinic Procedures, In-Person Sessions, Telehealth and Phone Guidelines. I understand the risk of COVID-19 and agree to participate in all safety procedures and care. I agree to pay the fee assigned above. I agree that consent to services remains in effect as long as I attend the Gerald & Audrey Olson Marriage & Family Therapy Clinic and/or Mount Mercy University Counseling Center and can only be revoked by me in writing with such notice being provided to the clinic.

☐ I have read this form and I AGREE to receive counseling services.

☐ I have read this form and I DECLINE to receive counseling services.

_____Date

Print Client Name/Legally Authorized Person	Signature	Relationship to Clien
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
Therapist Name	Signature	Relationship to Client

Any concerns, questions or grievances may be reported to supervisor or the Clinical Director at (319-368-6493)

RELEASE OF INFORMATION- PARENT/ GUARDIAN

I, _____, hereby authorize the Gerald and Audrey Olson Marriage and Family Therapy Clinic (hereinafter referred to as the Olson MFT Clinic) to release verbal and/or written information to:

_____ _____ _____
Full name of person or entity Phone Fax

_____
Address

For the following purposes:

□ Treatment and assessment □ Coordination of care □ Referral of new or additional services

□Other_____

Specific information to be released includes:

□ Assessment and diagnosis □ Treatment goals □ Session Content □ Discharge

□ Other: _____

I understand that by signing this General Authorization I am authorizing the Olson MFT Clinic to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to the Olson MFT Clinic.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Olson MFT Clinic. I understand that my revocation of this General Authorization will not affect a disclosure that the Olson MFT Clinic has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Olson MFT Clinic's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date it was signed or on the specified date of ____/____/_____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)

_____Mental Health _____Substance Abuse _____HIV/AIDS _____ Genetic information including genetic test results

_____ _____ _____
Print Client Name/Legally Authorized Person Signature Date

_____ _____ _____
Therapist Name Signature Date

DEMOGRAPHIC FORM – PARENT/GUARDIAN

Name: _____

Name of child: : _____

Age of child: : _____

My relationship to the child is: _____

Who has legal custody of the child? _____

My child identifies their gender as: _____

My child's preferred pronous are: _____

My child identifies their race and/or ethnicity as: _____

My child's religious religious affiliation is (if any):_____

My child's highest level of education obtained?_____

Number of individuals in my household is:_____.

My household income is: _____

On average, I work about _____ hours per week.

My child's relationship status?

- Single
- In a relationship

What is your relationship status?

- Single
- Married
- Separated
- Divorced
- Cohabitating/Live with
- Other _____

Please mark if applicable:

- ☐ I am a veteran / a family member of a veteran.
- ☐ I am a Mount Mercy University faculty, staff, student and/or a family member of a Mount Mercy University faculty or staff member
- ☐ I am a COVID first responder/family member

How did you hear about us?

_____

BIOPSYCHOSOCIAL FORM

Current Symptom Checklist

MY CHILD IS FEELING…	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					

MY CHILD IS EXPERIENCING…	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					

I NOTICE MY CHILD…	Never	Rarely	Sometimes	Frequently	For how long?
Is Angry, Irritable, Hostile					
Is euphoric, energized and highly optimistic					
Has racing thoughts					
Is needing less sleep than usual					
Is more talkative					
Mood fluctuates: go up and down					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

MY CHILD HAS …	Never	Rarely	Sometimes	Frequently	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
MY CHILD'S EATING INVOLVES…	**Never**	**Rarely**	**Sometimes**	**Frequently**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					
MY CHILD HAS …	**Never**	**Rarely**	**Sometimes**	**Frequently**	**For how long?**
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
If yes, who / what / why (list all):

_____

_____

_____

Relationship and Family History

Relational status

- Single
- Married
- Separated/Divorced
- Cohabitating
- Other _____

Intimate relationship

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

Relationship satisfaction

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

List family members

Name	Age	Gender	Relationship to Client

Describe any past or current significant issues in intimate relationships or immediate family relationships:

Medical History

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ **Not applicable**

List any known allergies ☐ **Not applicable**

Substance and Alcohol Use History

I USE THE FOLLOWING…	Never	Rarely	Sometimes	Frequently	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Client Treatment History

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
- ☐ 12-step program (age[s]) ____
- ☐ Stopped on own (age[s]) _____
- ☐ Other (age[s]) _____

ces of Substance and/or Alcohol Use

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ Binges
- ☐ Arrest(s)

Family alcohol/drug abuse history

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ sibling(s)
- ☐ stepparent/live-in
- ☐ uncle(s) and/or aunt(s)
- ☐ spouse/significant other
- ☐ children
- ☐ other _____

- ☐ Withdrawal symptoms
- ☐ Medical conditions
- ☐ Increase of Tolerance
- ☐ Loss of control over amount used
- ☐ Job Loss
- ☐ ☐ Other: _____
- ☐ Sleep disturbance
- ☐ Assault(s)
- ☐ Suicide Attempt(s)
- ☐ Suicide Impulse/Thoughts
- ☐ Relationship Conflicts

Socio-Economic Status History

Living situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Financial situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ supervisor conflicts
- ☐ unstable work history
- ☐ disabled:_____

Legal history

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s), total time served: _____