INFORMED CONSENT: PARENT/GUARDIAN

Consent:

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

The Gerald & Audrey Olson Marriage & Family Therapy Clinic is a teaching clinic and therapy will be 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 therapist 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.

All student therapists and faculty supervisors are required to hold information about sessions and clients in confidence. **The 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 this policy are the following circumstances:

1. _______ (initial) There is clear and imminent danger to you or others in which case the clinic may be required to inform the responsible authorities or warn the identified victim. In the event that this occurs, the therapist will inform you of their responsibilities and actions.

2. _______ (initial) 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. _______ (initial) The clinic maintains records of treatment, diagnosis, assessment, and treatment planning in order to collaborate with clinic staff and supervisors, and to better inform your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among clinic staff, but Gerald & Audrey Olson Marriage & Family Therapy Clinic is not required to agree to those restrictions.

4. _______ (initial) Since Gerald & Audrey Olson Marriage & Family Therapy Clinic is training facility, you agree that staff, clinical supervisors and other therapists may have access to confidential information for the purpose of clinical effectiveness. Therapy sessions are videotaped for review, and in signing this informed consent I am agreeing to allow The Gerald & Audrey Olson Marriage & Family Therapy Clinic to videotape my sessions. I understand that videotapes of sessions will be deleted at the termination of a student therapist's training in the program.

5. _______ (initial) If the release of information is mandated by law. Some litigation may require the release of records even without the client's authorization. Student therapist 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. ______ (initial) 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.

______(initial) I understand that The Gerald & Audrey Olson Marriage & Family Therapy Clinic is not a crisis center, and is not staffed or qualified as one. I agree that if I am in 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 Gerald & Audrey Olson Marriage & Family Therapy 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 fee unpaid 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).

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 Gerald & Audrey Olson Marriage & Family Therapy Clinic's Notice of Private Practices. I fully understand its contents and if I had any questions regarding this document it has been fully answered.

Research:
______ (initial) I am aware the Olson MFT Clinic uses all client paperwork and video 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 further ensure confidentiality, 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, I, or my supervisor/clinical director, may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I, or my supervisor/clinical director, believe it is necessary, I 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, I 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 has put in place preventative measures to reduce the spread of COVID-19; however, MMU and 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 or the 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) By initialing You understand that The Olson Clinic has 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 The Olson Clinic personally liable of actions/inactions other individuals have/have not taken to limit the spread of infection.

_____ (initial) I acknowledge the contagious nature of COVID-19 and 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) I understand that the risk of becoming exposed to or infected by COVID-19 at MMU or The Olson Clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to, MMU or Olson Clinic staff/employees, faculty, volunteers, students, and other professionals 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 or 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, 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 or The Olson Clinic, its, 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:

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.

_____ (initial) You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.

_____ (initial) We cannot provide a mask or face shield for you. You will bring and wear a mask to all appointments and always wear while inside the CRST Graduate Center/Olson MFT Center.

During a Session:

_____ (initial) You will wear a mask and/or face shield in all areas of the office/rooms/graduate center (all faculty, staff, and students will too).

_____ (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 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.

_____ (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

The Olson Clinic has taken steps to reduce the risk of spreading the coronavirus within the clinic and we have posted my efforts on my website and in the office (also see posted this COVID informed consent form on the website). 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 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 AND PHONE 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 individuals 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.

_____ (initial) I understand & agree to each of the following statements regarding telehealth:

- 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.
- I understand the risks of receiving communicating with my therapist about appointment times via email and I still prefer to receive these.
- I understand that all electronic communication is a part of my legal medical record.
- I understand that I have to be physically located in the State of Iowa at the time of my session, If I am not I understand I must reschedule the session.
- I understand I am to not be in the act of driving. If I am, understand the session while be rescheduled.

- I understand that in very rare instances, security protocols could fail, causing a breach of privacy of personal therapeutic information.
- I also understand that the Olson MFT Clinic is utilizing a new suicidality protocol during this time while doing telehealth sessions. I understand I will be asked EVERY session before starting session if I have any suicidal thoughts, ideation, plan or intention. I understand, 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 this confirmation of safety. I understand I tell my therapist I have intents or plans of suicide my therapist will call mobile crisis and/or police to come to me.

Phone Sessions:

_____ (initial) Phone sessions are however 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 I cannot promise full confidentiality due to conducting these sessions from home offices during the crisis. By agreeing to either phone or Zoom video session, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

FEES

Fees:

Fees for service (in person, telehealth, or phone) will be _________ **[For Student Therapist to fill out, do not fill out]** per session, unless other arrangements have been made with the therapist prior to service. These fees are determined on a sliding fee scale 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
Poverty 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 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 Client
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 my therapist or the Clinical Director at (319-368-6493).

The Olson Marriage & Family Therapy Clinic

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

The Olson Marriage & Family Therapy Clinic

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]) _____

Family alcohol/drug abuse history

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

ces of Substance and/or Alcohol Use

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