



Stephanie Meagher MA MFT
Individual and Couples Counseling

Welcome! Thank you for scheduling a new client appointment with me. I believe that having a good client/therapist fit is key to a successful therapy experience so I appreciate you picking me, and I look forward to the opportunity to work with you!

In this packet you will find several forms for you to read and fill out. Please feel free to call or email me if you have any questions about these documents. The forms are as follows:

- Professional Disclosure Statement (PDS) - please read, sign and date
- Client Consent to Treatment - please read, sign and date
- Adult Intake Form - please fill this out as completely and honestly as possible; it will help me to get to know you and understand more about what is bringing you to therapy

Please complete all these forms and bring them with you to your first appointment. Thank you!

It is my desire to come alongside you with encouragement, education, and care. During therapy I will build a collaborative relationship with you in which we can work to help you gain insight, understanding, and change. To accomplish this relationship, I will strive to understand your background, relationships and life experiences so that I can best help facilitate your goals.

Your role is equally important. I encourage you to come to therapy prepared to:

- Be honest with yourself and your therapist
- Be open to processing the thoughts, feelings, and questions which come up in therapy
- Be consistent in your scheduling so that you can optimize the process
- Stick with it! Therapy can be challenging; believe in the process and be willing to stick with it through the highs and lows

Please feel free to contact me with any questions about these forms. Otherwise, I look forward to meeting you at our first session.

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PROFESSIONAL DISCLOSURE STATEMENT

Philosophy and Approach: I believe that people develop within relationships - in other words, we affect others and are affected by them. Having an emotionally fulfilling relationship with ourselves and others is important for our mental, physical, social, and spiritual health. Sometimes the way we act, react, and experience emotions within relationships becomes challenging. Our ability to process information gets stuck and we develop negative patterns of interacting. These patterns make it difficult to maintain a healthy and adaptive relationship with ourselves and others. My approach draws upon Emotionally Focused Therapy, as well as ideas from developmental, systems, and attachment theories. I work collaboratively with clients to explore how past relationships and life experiences influence current emotional and behavioral patterns which cause conflict and disconnection. Together we identify and alter the emotional and behavioral patterns that are no longer working, and transform these into positive relational patterns.

Formal Education and Training: I hold a Bachelor's degree in Family Studies and Gerontology from Oregon State University, and a Master's Degree in Marriage and Family Therapy from George Fox University. Major coursework includes Human Growth and Development, Personality and Counseling, Human Sexuality, Social & Cultural Foundations, Psychopathology, Couples Therapy, Family Therapy, and Relationship Assessment. Specialized coursework includes Emotion Focused Couples Therapy, Play Therapy, Child Parent Relationship Therapy, and Sandtray Therapy.

Licensure: I am registered with the Oregon Board of Licensed Professional Counselors and Therapists and am pursuing state licensure as a Licensed Professional Counselor (LPC). As such, I abide by the Oregon Board of Licensed Professional Counselors and Therapists Code of Ethics. I receive ongoing post-graduate supervision from Don Thomson, M.S., L.P.C., A.C.S. My supervisor is bound by the same confidentiality requirements as me. If you have questions, I am happy to explain the details of the supervision process to you.

Fee Schedule & Policy:

Fees are due at the beginning of the session and payable by cash or check or credit card.* These services may be covered in full or part by your health insurance or employee benefit plan. I do not deal with insurance companies directly; therefore, it is your responsibility to determine whether the insurance company will reimburse my services. At your request I can supply you with an appropriate receipt that you may use to seek reimbursement from your insurance company.

To cancel or reschedule an appointment, please notify me **no later than 5:00 p.m. the previous day** by calling my office. If you are unable to reach me directly, please leave a voicemail. If you fail to cancel a scheduled appointment, I cannot use this time for another client, and you will be billed for the entire cost. Exceptions are made for emergencies and inclement weather.

**Please note, you will be charged a fee of \$35 for any returned checks*

<i>Service</i>	<i>Fee</i>
Intake Appointment (80 minutes)	\$120
50-minute therapy session	\$80
80-minute therapy session	\$120
80-minute Co-therapy session (couples)	\$200

Emergencies and Mental Health Crisis:

I am not available on an on-call basis for emergencies. If you have a crisis or emergency requiring immediate attention, please call the crisis line for your county.

Marion County Crisis Line

503-585-4949

OR go to the nearest emergency room

As a client of a Registered Intern you have the following rights:

1. To expect that a Registered Intern and their licensed supervisor have met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a Registered Intern;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: a) Reporting suspected child abuse; b) Reporting imminent danger to client or others; c) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; d) Providing information concerning licensee case consultation or supervision; and e) Defending claims brought by client against licensee;
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

If you have any questions regarding the counseling process or this disclosure statement, feel free to ask. If at any time and for any reason you are dissatisfied with my services, please let me know. If we are unable to resolve your concerns, you may report complaints to **The Oregon Board of Licensed Professional Counselors and Therapists at 3218 Pringle Rd. SE #250, Salem, OR 97302-6312, (503) 378-5499.**

By signing this Professional Disclosure Statement, I, the client, acknowledge that I have both read and understood all the terms and information contained herein. Opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature

Date

Client Signature

Date

Stephanie Meagher, MA MFT

Date

___ I have received a copy of the PDS and Consent for Treatment (initial)

STEPHANIE MEAGHER, MA MFT
(503) 505-1109

355 High Street SE
Salem, OR 97301

CLIENT INFORMATION AND CONSENT TO TREATMENT

Treatment

It is important for you to understand that the primary goal of any treatment approach is to bring about change. The therapy process can be fun and exciting. It can also be hard work; at times challenging, difficult, and even painful. Exploring feelings, past experiences, and relationships may create or increase feelings of discomfort, anxiety or depression at some point during treatment. If you experience an increase in discomfort please let me know so that we may address this together. If at any point during treatment you have questions or concerns about the progress of our work together I encourage you to discuss your concerns with me. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I understand that my involvement in the therapy process is vital and agree to play an active role.

Right to Refuse Treatment

I am aware that I may stop my treatment with this therapist at any time. I understand if I stop treatment I am still responsible for paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) If you decide to discontinue treatment I will be happy to provide a referral to another therapist or other resources.

Confidentiality

Privacy and confidentiality of information disclosed in session is of the utmost importance to me. In order to provide you with the best care, I consult routinely with my supervisor about my clients and, from time-to-time, with my mental health colleagues. When consulting with other professionals, I will not share your identity and will mask any identifying information to preserve your privacy and confidentiality. My supervisor and colleagues are obligated to observe the same confidentiality requirements as I am. Situations and or information that require me by law to break confidentiality include but are not limited to: suspected child, dependant adult, or elder abuse or neglect, client threat of serious bodily harm to another person, and client intent to harm self. A fuller listing of possible breaches of confidentiality is disclosed in my Professional Disclosure Statement and Notice of Privacy Practices. My colleague Michelle J. Cox provides back-up emergency client care for me when I am sick or on vacation. In the event of my death or incapacitation, Michelle J. Cox will be responsible for notifying my clients, making referrals, and turning over files or destroying them if appropriate. Please feel free to address any concerns you have about confidentiality with me.

Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices. I have had all my questions answered fully.

Appointments and Cancellations

Sessions are either 50 or 80 minutes in length. To cancel or reschedule an appointment, please notify me **no later than 5:00 p.m. the previous day** by calling my office. If you are unable to reach me directly, please leave a voicemail. If you fail to cancel a scheduled appointment, I cannot use this time for another client, and you will be billed for the entire cost of your missed session. Exceptions are made for emergencies and inclement weather.

Acknowledgement of Information and Consent for Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize Stephanie Meagher, MA MFT, to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive from Stephanie Meagher at any time.

By signing this Client Information and Consent form, I, the client, acknowledge that I have both read and understood all the terms and information including possible risks contained herein. Opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature

Date

Printed Name

Date

Client Signature

Date

Printed Name

Date

As Witnessed by:

Stephanie Meagher, MA MFT

Date

Today's Date _____

**Anam Cara Counseling, LLC
Stephanie Meagher, MA MFT
Client Information Form**

A. Identification

Your full name: _____

Date of birth: _____ Age: _____ Gender: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Please indicate which numbers I can leave a private message for you: _____

Email: _____

In the event of an emergency, whom do you want me to contact?
Name _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Email address: _____

B. Referral: How were you referred to me? _____

If referred by another person, how did this person explain how I might be of help to you? _____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation Protestant Catholic Jewish Islamic Buddhist Hindu

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: _____

D. Your health & medical care:

Clinic/doctor's name: _____ Phone: _____

Address: _____

Are you currently being treated for any health problems? Yes No

If yes, please specify _____

Any previous illnesses, injuries, health problems or treatments (from childhood to present)? Yes No

If yes, please specify, along with treatment received:

Please list all medications you presently take including prescription, over-the-counter, and herbal supplements.

Name	Amount	Frequency	For what?

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?

Do you have problems sleeping? Yes No If yes, describe: _____

Do you have problems with eating or food? Yes No If yes, describe: _____

How would you rate your current health? Excellent Good Average Poor Failing

E. Chemical use

1. How many cups of regular coffee do you drink each day? _____ Tea? _____ Soda/Pop w/ caffeine? _____

How many "energy drinks"? _____ How often do you use No Doz or similar caffeine pills? _____

2. How much tobacco do you smoke or chew each week? _____

3. How much beer, wine, or hard liquor do you consume each week, on the average? _____

4. Have you ever felt the need to cut down on your drinking? No Yes

5. Have you ever felt annoyed by criticism of your drinking? No Yes

6. Have you ever felt guilty about your drinking? No Yes

7. Have you ever taken a morning "eye-opener"? No Yes

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? No Yes

9. Are you in a recovery program? No Yes If yes, which program? _____

10. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? No Yes

If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

F. Mental Health History

Have you ever received counseling services, or psychological, psychiatric, or drug or alcohol treatment before? (Include hospitalizations). No Yes If yes, please indicate:

Type of treatment?	When?	For what? (included any diagnosis given)	With what results?	How helpful was it?

Have you ever contemplated or attempted suicide? Yes No If yes, describe when, why, how:

Do you currently feel like harming yourself or committing suicide? Yes No Harming others? Yes No

Has any member of your family committed suicide? Yes No If yes, relationship to you: _____

Any family members ever hospitalized with a mental illness? Yes No Who/What: _____

Any family members ever diagnosed with a mental illness? Yes No Who/What: _____

G. Education and job history

Number of years of education completed: _____ Degree completed - check the appropriate box below:

- High School Graduate GED Vocational/Trade School Associates degree Bachelors degree
 Masters Degree Doctorate Degree Other

Did you have a learning disability as a child? Yes No Do you currently? Yes No

Have you served in the military? Yes No Which branch? _____ Type of discharge: _____

How long employed in present job? Yrs: ___ Months: ___ If not working, how long unemployed? Yrs: ___ Months: ___

What is the longest period you worked at one job? Yrs: ___ Months: ___

What is your present type of work? _____

What other types of jobs have you held? _____

Interests and hobbies: _____

H. Significant nonmarital relationships

	Name of partner	Partner's age (at time of relationship)	Your age (at time of relationship)	Reasons for ending
First				
Second				
Third				
Current				

I. Marital history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?
First					
Second					
Third					

J. Children In the last column, indicate adopted children with an "A", biological children with a "B", foster children with an "F" and step-children with an "S".

Child's Name	Age	Sex	Grade	Academic, Behavioral, or Medical Issues?	Does child live with you? (Y or N)	Relationship (A, B, F, S)

K. Family-of-origin history

Please write names in the spaces below. Under illnesses, include addictions and mental health issues.

Relative	Age (or age at death)	Illnesses (or cause of death)	Education (highest level reached)	Occupation	Status of relationship (strong, fair, strained)
Father					
Mother					
Brothers					
Sisters					
Stepparents					
Grandparents					
Aunts/Uncles					

Were you adopted? Yes No If yes, at what age? _____ By whom: _____

Were you ever in foster care or a similar living situation? Yes No

Were the adults in your home abusive to each other? Yes No

Were any of your brothers or sisters abused? Yes No physically, sexually or emotionally (circle one)

E. Abuse history:

I was not abused in any way. I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters:

P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse.

N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of Abuse	By Whom?	Effects on You?	Whom did you tell?	Consequences of telling?

H. Legal history

List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: **F** = federal, **S** = state, **Co** = county, **Ci** = city.

Under "Sentence," write in the time and the type of sentence you served or have to serve (**AR** = accelerated or alternate resolution, **CS** = community service, **F** = fine, **I** = incarceration, **Pr** = probation, **Po** = parole, **O** = other, **R** = restitution).

Date	Charge	Jurisdiction (F,S,C,Ci)	Sentence (AR, I, Pr, Pa)	Probation/Parole Officer's name	Your attorney's name

Please describe the main difficulty that has brought you to see me and what you hope to achieve in therapy: