WALK & TALK THERAPY INTAKE & CONSENT FORM

Jeffrey Adorador, MS - Licensed Marriage Family Therapist # 80129

Date:______________Name:____Age:_______ DOB:_______________

Address:____

Contact Number(s): Cell: (_____)________________________ Other: (_____)________________________

E-mail address:____

EMERGENCY CONTACT: ____

Name of Additional Participates of Counseling: ____
Marital Status: ____ Single _____Partner ____ Engaged ____ Married ____ Separated ____ Divorced

Name of Spouse:____
Number of Children & Ages: ____
Presently Living with: ____ Parents ____ Spouse ____ Roommate ____ Alone ____ Other

Education:___________________________________Occupation:____
Currently Working: ____ Yes ____ No
Do you have a distracting Medical Issue? ____ Yes ____ No
If so, please explain.____
Have you ever been diagnosed with a mental health disorder? ____ Yes ____ No
If so, please explain.____
Are you currently on psychiatric medication? ____ Yes ____ No
If so, please explain.____
Do you have a history of suicidal ideations, attempts or hospitalization? ____ Yes ____ No
If so, please explain.____
Are you currently suicidal: ____ Yes ____ No
Do you have a history of drug use or abuse? ____ Yes ____ No
If so, please explain.____

Primary Reason for Counseling:

____

____

____

Level of Fitness/Conditioning: Circle the appropriate number which best describes client.

1 = Client does not exercise regularly.
2 = Client exercises regularly.
3 = Client is a competitive athlete and trains regularly.

Health Information: Place a mark in the box "Yes" or "No" if you have any of the following:

Allergies:	☐ **Yes** ☐ **No**	**If so, please state allergies(s):**______________________________	
Asthma:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**
Back pain:	☐ **Yes** ☐ **No**		
Chemical Dependency:	☐ **Yes** ☐ **No**		
Diabetes:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**
Epilepsy:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**
Heart Condition:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**
High Blood Pressure:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**
Stroke:	☐ **Yes** ☐ **No**	**If so, are you packing medication into the field ?**	☐ **Yes** ☐ **No**

Additional condition(s):____

I________________________________have read and discussed with my therapist the details of Walk & Talk Therapy. I have agreed to have my therapy sessions outdoors and can request office time in advance if needed and if I desire.
By signing this form, I further agree to the following:

- I agree to pay fees at start of session, check or cash preferred.
- I understand that I will be charged for a missed appointment without a 24 hour notice of cancellation
- I agree that I am responsible for setting the walking pace of the sessions
- I agree to seek my doctor's approval before walking if appropriate.
- I take full responsibility for any medical and physical well-being of mine and will not hold Jeffrey Adorador, LMFT, or Earthwalker LLC financially responsible for any medical conditions and/or accidents/pains that may arise as a result of walking.
- I agree to communicate with my therapist if I am uncomfortable physically or emotionally while participating in Walk & Talk Therapy.
- I understand that if we come into contact with a person I know, I have the right to disclose or not to disclose that I am in a therapy session. I understand that my therapist will follow my lead should we come into contact with a person I know. My therapist will make every effort to preserve client confidentiality and privacy while conducting my Walk & Talk Therapy session.
- I understand that nature, the weather, various temperature changes, visual distractions, and parallel experience with my therapist in the environment is part of my therapy process and experiences.
- I agree to self-care and will bring water, nourishment and the proper attire as needed for our walk.
- I understand and agree to the above regarding Walk &Talk Therapy.

Client name (print)____

Signature__________________________________Date______________________________

Phone:_________________________________ email:_________________________________

WALK & TALK THERAPY MINOR CONSENT

I acknowledge that I have received and understood the information about Walk and Talk Therapy that I am considering for the minor/child. It is understood that the minor/child will be participating in Walk and Talk Therapy. I have had all my questions answered fully. My signature below indicates that I have read this agreement for services carefully and understand and agree to its contents.

I, ____, having legal custody, hereby consent to
(printed name of legal guardian)

mental health treatment for ____ with Jeff Adorador, LMFT.
(name of minor)

____ ______________________________
Parent/Guardian Signature *Date*

(print)____