Adult Intake Questionnaire

This questionnaire is designed as an aid to the intensive information gathering that usually takes place during the initial 1-2 psychotherapy sessions. As with therapy itself, the information you provide is kept confidential. You do not have to answer questions that you and your therapist have already covered. You may also leave items blank if you do not wish to answer them.

Your Name: _____

Address: _____

Phone: (Home) _____ (Work) _____

(Cell)_____ (Other, please specify) _____

Email (if OK to use) _____

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referred by _____ Phone_____

REIMBURSEMENT If you would like us to send you a monthly statement which you can forward to your insurance company to request reimbursement, please indicate below:

Monthly statement (circle one): Yes No

If you plan to seek reimbursement, it may help to provide your social security number here, so that it will appear on your monthly statement: _____

Age: _____ Gender: _____ Date of birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: Protestant Catholic Jewish Muslim Buddhist No affiliation

(circle one) Other: _____

Is adult religion different from childhood religion? If so, please explain:_____

Marital status: Single, never married Married Separated Divorced

(circle one) Widowed Cohabiting

If you divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Education: (number of years completed) _____ Highest degree held: _____

Occupation: _____

Are you working now? No Yes (circle one) If yes, circle one: Full-time Part-time

Are you going to school now? No Yes (circle one) If yes, circle one: Full-time Part-time

Names of persons living in your home and your relationship to them:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse/partner's occupation, if applicable:_____

Please provide the following information about your family:

Mother Name: _____

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Give a description of your mother's personality and her attitude toward you (past and present): _____

_____

Father Name: _____

If deceased, year and cause of death:_____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Give a description of your father's personality and his attitude toward you (past and present): _____

_____

If you were not brought up by your parents, who raised you and between what years? _____

Siblings:

Name	Age	Occupation	Where does s/he live?

Where did you grow up?_____

Were your parents ever separated? Yes No (circle one) If yes, when?_____

Did your parents get divorced? Yes No (circle one) If yes, when? _____

Did they remarry? Yes No (circle one) If yes, when? _____

At what age did you move out of your parents' home? _____

Circle any of the following that applied during your childhood and/or adolescence:

Happy Childhood	Strong Religious Convictions	School Problems	Medical Problems	Alcohol Abuse
Unhappy Childhood	Emotional/Behavior Problems	Family Problems	Legal Trouble	Drug Abuse

Did you ever leave a school you were enrolled in prior to completion? Yes No (circle one)

If yes, give details: _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)?

Yes No (circle one) If yes, give details: _____

_____

If you were physically disciplined as a child, were you ever injured as a result? Yes No (circle one)

Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? Yes No (circle one)

Did you ever have sexual contact with someone else that you did not want? Yes No (circle one)

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No (circle one)

Have you experienced physical or sexual abuse or assaults? Yes No (circle one)

Please provide some general information on your work history:

Type of job held — How long?

_____

_____

_____

If you have a partner or spouse, how long have you been together? _____

Please list names and ages of your children, if applicable:

Name	Age	Biological?	Name	Age	Biological?
		Y/N			Y/N
		Y/N			Y/N

Please describe, briefly, the problem(s) that bring you in to see me.

What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

Have there ever been problems like this before? Yes No (circle one)

If yes, when? _____

Are you troubled by any mental images (unpleasant childhood images, aggressive images, pleasant or unpleasant sexual images, lonely images)? If so, please explain: _____

How often do you have nightmares? _____

Are you presently seeing another therapist? Yes No (circle one)

If yes, please give us the following information:

Therapist's name: _____ Date treatment began: _____

Therapist's address:_____

Therapist's phone number: _____

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy? Yes No (circle one)

If yes, please give us the following information:

Therapist's name(s), phone number(s) and address(es): _____

_____

_____

Date(s) of treatment : _____

Problem for which treatment was sought:_____

If you have been in psychotherapy before, was it helpful? Yes No (circle one)

If yes, in what way was it helpful? _____

If not, in what way was it unsatisfactory? _____

In a few words, what do you think therapy is all about? _____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

Have you ever attempted suicide? Yes No _____

Has any relative attempted or committed suicide? Yes No _____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you? Yes No (circle one) If yes, when and why? _____

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? Yes No (circle one) If yes, when and why? _____

Was the hospitalization voluntary? Yes No (circle one)

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties (e.g. Prozac, Xanax, etc.)? Yes No (circle one)

If yes, what medications were recommended, when and for what symptoms?

_____

Have you ever taken medications for mental or emotional difficulties prescribed by a physician/psychiatrist?

Yes No (circle one)

If yes, what medications were prescribed, when and for what symptoms?

_____

Are you currently using any prescribed medications? Yes No (circle one)

Please indicate what medications you are taking:

Medication Dosage When started Prescriber

_____

_____

_____

_____

_____

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, prescribed drugs (e.g. valium), Ecstasy and others)

Yes No (circle one) Are you currently using? Yes No (circle one)

If yes, please check which ones and fill out the requested information:

Type Frequency/amount Duration How taken

_____

_____

_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? Yes No (circle one)

If yes, please explain: _____

_____

Do you drink alcohol? Yes No (circle one)

If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drinking?

Yes No (circle one)

Have people annoyed you by criticizing your drinking?

Yes No (circle one)

Have you ever felt bad or guilty about your drinking?

Yes No (circle one)

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Yes No (circle one)

How much alcohol do you drink? _____drinks per _____

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No (circle one)

If yes, please explain: _____

_____

Has treatment for drug or alcohol abuse ever been recommended to you?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been treated for drug or alcohol abuse?

Yes No (circle one)

If yes, please describe the provider and program, give dates and describe the outcome.

_____

_____

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No (circle one)

Do you make friends easily? Yes No

Do you keep them? Yes No

Is your present sex life satisfactory? If not, please explain: _____

_____

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No (circle one)

If yes, please describe: _____

Have you ever sustained a concussion or other head injury? If so, please explain: _____

_____

List dates of any hospitalizations you have had for physical problems:

Date Problem

_____

_____

_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

_____

_____

Have you ever been involved in a lawsuit?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been arrested for a crime?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you experienced any particular sources of stress in the last year?

Yes No (circle one)

If yes, please explain: _____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment?

Yes No (circle one)

If yes, please give details: _____

_____

_____

_____

Is there any other background information you think would be helpful for me to know?

Yes No (circle one)

If yes, please explain: _____

_____

_____

_____

_____ _____

Signature Date

DASS21

***Date**:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

Treatment/Evaluation Agreement

This document contains important information about the professional services and business policies of Kathrine Gapinski, Ph.D. and the San Francisco Group for Evidence-Based Psychotherapy. Please read it carefully and discuss any questions you have with Dr. Gapinski.

ASSESSMENT AND TREATMENT: Dr. Gapinski will provide an assessment of your difficulties and available treatment options. If she recommends and you agree, she will provide a form of evidence-based psychotherapy (cognitive-behavioral therapy or dialectical behavior therapy, most commonly), which has been shown in controlled outcome studies to be effective for a number of problems and disorders. (Dr. Gapinski will review the outcome data most pertinent to your situation upon request.) However, no guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety; and it may result in changes that were not originally intended (such as remaining in a relationship or job you believed you would leave). There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your situation, Dr. Gapinski will offer, if you would like, an estimate of the number of sessions of treatment she recommends for you. For most patients, this ranges between 5 and 40 sessions. Dr. Gapinski's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to the treatment that Dr. Gapinski can provide are available, including other types of individual psychotherapy, group, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures can be helpful in some cases, and if Dr. Gapinski recommends this in your case, she will let you know what her recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Dr. Gapinski will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Dr. Gapinski is a psychologist licensed to practice in California (License # PSY 19918). She graduated from Yale University with a Ph.D. in Clinical Psychology, completed her internship at the San Francisco VA Medical Center, and received postdoctoral training at Stanford University Medical Center in the Department of Psychiatry's Behavioral Medicine division. Her research background is in eating and anxiety disorders, and she is published in both areas. She served for over 2 years as Clinical Coordinator of the research-based, cognitive-behavioral Shyness Clinic in Los Altos, and was subsequently Director of Adult Services there. She has facilitated support groups for medical residents at the University of California, San Francisco (UCSF). She is an adjunct faculty member at the University of San Francisco, where she teaches regularly, and she has periodically taught college courses at other Bay Area institutions, including UC Berkeley Extension. Her teaching interests and areas of

expertise include psychology of gender, psychology of sexuality, and abnormal psychology.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Dr. Gapinski to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with Dr. Gapinski in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled Patient's Bill of Rights, adapted from a publication by the California Department of Consumer Affairs, is attached to the end of this document. Please read it carefully and raise with Dr. Gapinski any questions you have about it.

HOURS/AVAILABILITY: Dr. Gapinski is usually available in the office from 9 a.m. until 6 or 7 p.m. on Mondays, Tuesdays, and Thursdays. Telephone sessions are sometimes available on other days, especially Wednesday afternoons. Therapy sessions are usually scheduled as 50-minute sessions weekly, or as your treatment needs dictate and you and Dr. Gapinski agree. Dr. Gapinski returns phone calls and emails daily when she is not in session. She does not carry an emergency pager and cannot promise to be reachable during the night or over weekends; however, she will make efforts to be responsive to your needs. In a crisis, you can call 911, contact your primary care physician, the local emergency room, or crisis intervention services. When Dr. Gapinski is out of town, she will let you know and will typically give you the name and telephone number of another therapist who will be available if she has concerns that she will not be reachable while away.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Gapinski will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information about you will be released by Dr. Gapinski only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Dr. Gapinski's judgment, you are in danger of harming yourself or are unable to care for yourself.
- if you communicate to Dr. Gapinski a serious threat of physical violence against another person (at which point Dr. Gapinski is required by law to inform both potential victims and legal authorities).
- if Dr. Gapinski is ordered by a court to release information as part of a legal proceeding, or as otherwise required by law.

In the event that group therapy services are provided, you are expected to keep materials shared in the group confidential. Dr. Gapinski cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Gapinski will provide you with a monthly statement that you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Gapinski will include this information on your statement. Dr. Gapinski will generally send this statement to you directly. If for some reason you and Dr. Gapinski agree that she will communicate directly with your insurance company, please be aware that when information is sent to an insurance company, Dr. Gapinski has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Gapinski cannot assure that they will do so. Some share information with a national medical information data bank for the purposes of determining eligibility for life, disability, health, and other insurance. Before Dr. Gapinski sends any information to an insurance company, she will talk with you about what she has written and she will obtain your permission to release the information. You do have a choice about whether to authorize the release of information requested by an insurance company, but if you refuse to consent to releasing it, most insurance programs will not pay for services.

You and Dr. Gapinski may elect to communicate via e-mail or text messaging. Email and text content should generally be limited to scheduling and sending documents (such as monthly statements and measures), unless it is being used as part of the therapeutic work (such as asking questions or reporting about homework). If you do contact Dr. Gapinski electronically, it is important to remember that if she is obtaining information only via e-mail, she is making clinical judgments on the basis of limited and imperfect information. She may not receive e-mail in a timely fashion, so if your communication is urgent, it may be best to also try the telephone. If you choose to correspond with Dr. Gapinski through e-mail, she will make every effort to keep the correspondence confidential, but she cannot guarantee the confidentiality of e-mail communications. If you communicate with her via e-mail or text, you agree to accept the risk that a breach of confidentiality may occur.

RECORD-KEEPING: Dr. Gapinski maintains a clinical chart for each patient. Information in the chart includes a description of your condition, your diagnosis, treatment goals, treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Gapinski also keeps records of any consent, release, assessment, or other forms completed in the course of your treatment. Clinical records are kept in a locked file cabinet and on a computer in Dr. Gapinski's office. The hard drive that includes the material from your clinical record is stored in a locked file cabinet when Dr. Gapinski is not in the office.

TAPING OF SESSIONS: It can occasionally be clinically useful to videotape or audiotape therapy sessions, but this will never be done without the knowledge and

consent of all parties and an agreement about how the material will be used and kept secure.

CONSULTATION: Dr. Gapinski may wish to consult with other professionals, especially her colleagues at the San Francisco Group for Evidence-Based Psychotherapy, about treatment planning for your case. The consultation process is meant to benefit you by improving upon your treatment. Your signature below gives Dr. Gapinski permission to do this, provided that she takes reasonable efforts to protect your identity.

RESEARCH, WRITING, TEACHING: Dr. Gapinski and others at the San Francisco Group for Evidence-Based Psychotherapy may conduct research, training, and supervision, and write for professional and lay audiences. Your signature below gives Dr. Gapinski permission to use information about you and your treatment in any of these ways, provided that she protects your identity.

FEES: Dr. Gapinski's fee is $200 per 50-minute session. Longer or shorter sessions are generally pro-rated from this fee. If you meet with Dr. Gapinski on the telephone for a 50-minute session, you will be charged the standard session fee. Of course, there will be no charge for contacts made to schedule appointments, or other brief emails and phone interactions, but if you require substantial contact over email or telephone in between sessions, you may be charged for this time at the above (pro-rated) rate. If you request that Dr. Gapinski prepare paperwork for you (for example, a treatment summary for another source), she may bill for the time that this requires. Generally she will not bill for time spent consulting with other current or previous treatment providers unless under unusual circumstances, as she considers this to be part of your treatment, but she may bill for time spent talking with parties whose counsel is believed to be peripheral to the treatment (for example, attorneys you may retain for purposes of outside litigation and with whom you request that she speak).

PAYMENT: Payment by check or cash is due at the time of each session unless another arrangement has been made. Dr. Gapinski will provide you with a monthly statement if you request one. If payment somehow becomes delinquent and you and Dr. Gapinski cannot come to an agreement about how it will be repaid, unfortunately she may have to engage the services of a collection agency and to disclose your identity, contact information, and outstanding session dates to said agency, generally after repeated attempts to contact and inform you (this is a rare outcome).

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source. You may wish to inquire with your insurance company about your benefits for "out-of-network providers."

FOR MEDICARE BENEFICIARIES: If you are receiving insurance coverage through Medicare, please be aware that Dr. Gapinski is not a Medicare provider. Your signature below indicates that you accept full responsibility for payment of Dr. Gapinski's fees. Additionally, your signature indicates that you will not submit claims to Medicare for Dr. Gapinski's fees or ask her to do so. Please note that Medicare limits do not apply to these

fees, Medigap plans will not cover them, and other insurance plans may not cover them. You have the right to obtain services from providers who are covered by Medicare. If you see a provider who is covered by Medicare, you do not have to sign a private contract (like this one) with that provider.

_____ (Client signature)

_____ (Therapist signature)

IF YOU ARE INVOLVED IN LITIGATION IN WHICH YOUR EMOTIONAL STATE OR PARTICIPATION IN THERAPY MAY BE RELEVANT: Dr. Gapinski prefers not to be involved in any litigation that you may participate in, even as a witness for emotional damages, because her participation in lawsuits can severely compromise your confidentiality, may inadvertently work against your case, and is not believed to be therapeutic. Should her participation be required either by your side or by the opposing side, you will be responsible for reimbursing her at the forensic rate of $350/hour for all time spent in the legal process, including report-writing, consultation with attorneys, testifying, and travel. This will be true regardless of her exact assigned role within the process, whether it be fact witness, expert witness, percipient expert or treating expert, etc.

CANCELLATIONS AND MISSED APPOINTMENTS: If an appointment is missed or cancelled without 48 hours notice, you will be charged for the session. Please be aware that insurance companies will not generally reimburse for a cancelled session. The cancellation policy is not meant to feel punitive, but is enforced out of a desire to be fair and consistent with all clients and to protect Dr. Gapinski's time, which she generally cannot use to help someone else without adequate notice.

TELE-TREATMENT (PHONE/INTERNET): Conducting therapy over the phone or internet (Skype) has its own benefits, risks and limitations. The primary benefit is easy access to care: if you the client are traveling, have moved, are sick or injured, or for any other reason are unable to attend a therapy session in person, then conducting therapy over the phone or internet may enable you to receive services that might be difficult or impossible otherwise. However, there are risks and limitations involved. While all of the confidentiality laws and protections apply, confidentiality is more difficult to ensure when information is being exchanged through telephone or internet services provided by third parties or companies (see confidentiality section below). In addition, when you and Dr. Gapinski do not meet in person, the lack of physical proximity may make it more difficult for Dr. Gapinski to accurately assess your health, well-being and safety. It may also be more challenging for Dr. Gapinski to quickly and effectively intervene if you need urgent care. Finally, you may also find that the distance and technical limitations of phone or internet sessions interferes with your experience of interpersonal connection and attunement with Dr. Gapinski. The appropriateness of tele-therapy in your case can be discussed as part of the ongoing therapy process.

GOOGLEDOCS: Dr. Gapinski sometimes uses Goggledocs for reporting and tracking homework. In general Goggledocs are considered secure, but as with all on-line interactions, confidentiality cannot be guaranteed. If you decide to use Goggledocs with Dr. Gapinski, you agree to accept the risk that a breach of confidentiality may occur.

SOCIAL NETWORKING: Finally, because confidentiality cannot be ensured on social or professional networking sites (such as Facebook and Linked In), Dr. Gapinski does not "link" with clients through any of these sites.

ENDING TREATMENT: You may withdraw from treatment at any time. Dr. Gapinski recommends that you discuss your plan to terminate treatment with her before taking action, so that she has an opportunity to offer her recommendations and referral options if they are needed.

If you discontinue meeting with Dr. Gapinski for a period of four weeks or more without warning or without an agreement for "as needed" sessions, she will typically attempt to contact you. If she is unable to reach you, she will assume that you have elected to terminate your treatment and she will close your case. Of course, should you wish to resume your treatment, she will be happy to discuss that option with you at any time.

*****
I have read and understood this agreement and the Patient Bill of Rights and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____

Date: _____

Patient Bill of Rights

You have the right to:
Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
Receive respectful treatment that will be helpful to you.
A safe environment, free from sexual, physical, and emotional abuse.
Ask questions about your therapy.
Refuse to answer any question or disclose any information you choose not to reveal.
Request that the therapist inform you of your progress.

Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
Refuse a particular type of treatment or end treatment without obligation or harassment.
Refuse electronic recording (but you may request it if you wish).
Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
Report unethical and illegal behavior by a therapist.
Receive a second opinion at any time about your therapy or therapist's methods.
Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.5.24.01