

**CLIENT HISTORY QUESTIONNAIRE**

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ (Fax) \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: (Name) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Relationship) \_\_\_\_\_

Will you give Dr. Beckner permission to contact this person in an emergency? **Y N**

Referred by \_\_\_\_\_

**REIMBURSEMENT**

A monthly statement can be provided to you at the end of the month, to give to your insurance company for reimbursement. The amount of reimbursement will depend on your insurance company's policy for covering out-of-network providers. Please indicate if you would like a monthly statement: **Y N**

May Dr. Beckner email your monthly statement to you? **Y N**

**BACKGROUND INFORMATION**

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Ethnicity (circle one): Caucasian African American Latino Asian Native America

Other: \_\_\_\_\_

Cultural Identity (country or culture where family is from) \_\_\_\_\_

Religious background (circle one): Protestant Catholic Jewish Muslim Buddhist No affiliation

Other: \_\_\_\_\_

Marital status (circle one): Single, never married Married Separated Divorced  
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? \_\_\_\_\_

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## WORK & EDUCATION

Education: (number of years completed) \_\_\_\_\_ Area of study \_\_\_\_\_

What is the highest degree you earned in school? \_\_\_\_\_ When? \_\_\_\_\_

Did you ever leave a school you were enrolled in prior to completion? **Y** **N** If yes, give details: \_\_\_\_\_

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

**Y** **N** If yes, give details: \_\_\_\_\_

Are you going to school now? **Y** **N** If yes, school & program: \_\_\_\_\_

Employment History \_\_\_\_\_ How long at job? \_\_\_\_\_

Current (place & position): \_\_\_\_\_

Previous (place & position): \_\_\_\_\_

Previous (place & position): \_\_\_\_\_

## RELATIONSHIPS

### Spouse / Partner

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Where does he/she live? \_\_\_\_\_

How long have you been together? \_\_\_\_\_

### Children

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Where does he/she live? \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Where does he/she live? \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Where does he/she live? \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Where does he/she live? \_\_\_\_\_

**People living in your home** (children, partner, relatives, housemates):

\_\_\_\_\_  
\_\_\_\_\_

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**Mother** Name: \_\_\_\_\_

If deceased, year of death      If living, Age      Occupation      Where does she live?

**Father** Name: \_\_\_\_\_

If deceased, year of death      If living, Age      Occupation      Where does he live?

**Siblings:**

Name      Age      Occupation      Where does s/he live?

**HISTORY**

Where did you grow up? \_\_\_\_\_

Were your parents ever separated / divorced?    **Y**    **N**      If yes, when? \_\_\_\_\_

Did they remarry?    **Y**    **N**      If yes, when? \_\_\_\_\_

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

If you were physically disciplined as a child, were you ever injured as a result?    **Y**    **N**

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)?    **Y**    **N**

Did you ever have sexual contact with someone else that you did not want?    **Y**    **N**

Have you experienced or witnessed any traumas (events that felt life-threatening)?    **Y**    **N**

Have you experienced physical or sexual abuse or assaults?    **Y**    **N**

**MEDICAL**

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?

**Y**    **N**      If yes, please describe: \_\_\_\_\_

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? \_\_\_\_\_

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Do any biological relatives have any history of psychological or emotional problems? **Y N**

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

| Relative (dad, aunt, etc.) | Problem or diagnosis | Treatment? |
|----------------------------|----------------------|------------|
|                            |                      |            |
|                            |                      |            |
|                            |                      |            |
|                            |                      |            |

## DRUG / ALCOHOL HISTORY

Do you drink alcohol? **Y N**

How much alcohol do you drink? \_\_\_\_\_ drinks per \_\_\_\_\_

Are you concerned about your drinking? **Y N**

Have you ever used any drugs or medications other than as prescribed? **Y N**

(includes prescription medications, marijuana, LSD, amphetamines, barbiturates, cocaine, opiates, Ecstasy, etc.)

If yes, please indicate what / when: \_\_\_\_\_

If you have used alcohol or any substances listed above, do you feel they have caused any problems in your work, school or relationships? **Y N**

If yes, please explain: \_\_\_\_\_

Have you ever been treated for drug or alcohol abuse? **Y N**

## LEGAL

Have you ever been involved in a lawsuit? **Y N**

If yes, describe & give dates: \_\_\_\_\_

Are you seeking an assessment / treatment related to a current or future legal case? **Y N**

Have you ever been arrested for a crime? **Y N**

If yes, please describe the circumstances and give dates.

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## WHAT IS BRINGING YOU IN TODAY?

Please describe, briefly, your current problem / issue

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Have there ever been problems like this before? **Y** **N**

If yes, when? \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

Have you had other psychological problems or symptoms in the past that are no longer bothering you? **Y** **N**

If yes, please describe and give approximate dates:

Problem

Dates

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## PSYCHOTHERAPY:

Have you ever had any psychotherapy or counseling, including individual, group, marital or family therapy? **Y** **N**

If yes, please provide the following information (start with most recent or current therapist)

Therapist Name & Phone \_\_\_\_\_ Was it helpful? If so, what was helpful? \_\_\_\_\_ Dates \_\_\_\_\_

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## MEDICATIONS:

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

If yes, please provide the following information (start with most recent or current medications)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Prescriber \_\_\_\_\_ Dates \_\_\_\_\_

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

If yes, please give details: \_\_\_\_\_  
\_\_\_\_\_

## **OTHER**

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

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **THERAPY/ EVALUATION AGREEMENT**

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

**ASSESSMENT AND TREATMENT:** Dr. Beckner will provide a thorough assessment of your difficulties and available treatment options. This generally involves a two-session consultation-assessment, which will cover background information, history of the problem you want help with, symptom measures, and goals for therapy. At the end of this process, she will make treatment recommendations, including whether she is the most appropriate therapist for your particular issue (see description of her specialties below). If Dr. Beckner determines that another clinician may be able to provide more effective treatment for your problem because it falls outside her areas of expertise, she will make appropriate referrals to other clinicians for you.

If you and Dr. Beckner agree to begin therapy together, she will provide the most appropriate evidence-based treatment for your particular problem or disorder. This will often include interventions from Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT). She will also provide you an estimate of the number of sessions appropriate for the treatment, which generally ranges between 5 and 50 sessions. However, it is important to note that effective treatment is often challenging, and no guarantees can be made regarding the success of therapy or the exact duration to achieve improvement. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety, and may result in changes that were not originally intended (such as deciding to divorce after coming for couples therapy, or staying in a job or relationship you intended to leave). There is a small risk that your condition will worsen due to treatment.

**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. Beckner do not meet in person, the lack of physical proximity may make it more difficult for Dr. Beckner to accurately assess your health, well-being and safety. It may also be more challenging for Dr. Beckner 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. Beckner. Given the research that demonstrates a strong connection between the therapy relationship and client improvement, such barriers to rapport may reduce the overall effectiveness of psychotherapy.

**ALTERNATIVE TREATMENTS:** Many alternative options for treatment are available beyond what Dr. Beckner may provide, 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. Beckner 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

# San Francisco Group for Evidence-Based Psychotherapy

*Victoria Lemle Beckner, Ph.D.*

aspects of treatment. Dr. Beckner will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

**TRAINING AND EXPERIENCE:** Dr. Beckner is a Psychologist licensed to practice in California (License # PSY 20789). She graduated from the University of Texas at Austin with a Ph.D. in Clinical Psychology, and received predoctoral training at the San Francisco VA Medical Center and postdoctoral training at the University of California at San Francisco (UCSF), where she currently teaches and does research as part of the clinical faculty. Dr. Beckner conducts research on the role of stress in physical and mental illness, and on the development and testing of effective treatments for anxiety and depression. She is lead author of the book *Conquering Post-Traumatic Stress Disorder*. In her clinical practice at the San Francisco Group for Evidence-Based Psychotherapy, Dr. Beckner specializes in the treatment of anxiety disorders (including worry, panic attacks, social anxiety, health anxiety, OCD, PTSD, phobias, and stress-related problems), depression and bipolar disorder, relationship issues, and coping with health/medical issues. She conducts both individual and couples therapy with adults.

**HOURS/AVAILABILITY:** Dr. Beckner see clients in her private practice on Mondays, Tuesdays & Thursdays, though she may sometimes schedule phone or Skype sessions on other days. Therapy sessions are usually scheduled as 50-minute sessions weekly, or as your needs dictate and you and Dr. Beckner agree. Dr. Beckner returns calls and emails usually within 24 hours, but cannot promise to be reachable during nights or weekends. In the event of a crisis or emergency, you can try to reach Dr. Beckner by phone at 415-845-4414, but if you don't reach her or are having a life-threatening emergency, you should call 911 first. You can also contact her by email ([beckner@sfpsychology.com](mailto:beckner@sfpsychology.com)), but always be aware that it is impossible to ensure confidentiality with email, and if the matter is urgent, please call instead. Dr. Beckner does travel for her research, and other professional obligations, as well as personal leave. When she is out of town, she will notify you ahead of time and provide you with the name and telephone number of another therapist who will be available during her absence.

**YOUR ROLE AS CLIENT:** You are expected to play an active role in your treatment, including working with Dr. Beckner 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. Beckner in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

**YOUR RIGHTS:** A document entitled "Patient's Bill of Rights," from a publication by the California Department of Consumer Affairs, is attached. Please read it carefully and ask Dr. Beckner any questions you have about it.

**CONFIDENTIALITY:** The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Beckner 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. Beckner only with your written permission, with the following exceptions:

- When there is suspected elder, dependent adult, or child abuse or neglect.
- When, in Dr. Beckner's judgment, you are in imminent danger of harming yourself or are unable to provide basic care for yourself.



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*Victoria Lemle Beckner, Ph.D.*

- If you communicate to Dr. Beckner a serious threat of physical violence against another person, Dr. Beckner is required by law to inform both potential victims and legal authorities.
- If Dr. Beckner 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. Beckner cannot be held responsible for a breach of confidentiality on the part of group members.

**Text & Email:** You and Dr. Beckner may elect to communicate via e-mail or text, and such correspondences may be kept as part of the medical record. If you decide to e-mail or text, Dr. Beckner will make every effort to keep the correspondence confidential, but she cannot guarantee the confidentiality of e-mail communications. If you communicate with Dr. Beckner via e-mail or text, you agree to accept the risk that a breach of confidentiality may occur. 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 email Dr. Beckner with a clinical concern, it is important to remember that she will be making clinical judgments on the basis of limited and imperfect information, and will generally want to follow up by phone or in person. Also, she may not receive e-mail in a timely fashion, so if your communication is urgent, it is best to call as well.

**Googledocs:** Dr. Beckner sometimes uses Goggedocs for reporting and tracking homework. In general Goggedocs are considered secure, but as with all on-line interactions and third-party service providers, confidentiality cannot be guaranteed. If you decide to use Goggedocs with Dr. Beckner, 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. Beckner does not “link” with clients through any of these sites.

**INSURANCE REIMBURSEMENT:** If you elect to seek reimbursement from an insurance company for your treatment, Dr. Beckner will provide you with a monthly statement you can submit to your insurance company. You are responsible for collecting reimbursement from your insurance company or other source. Dr. Beckner is not on any insurance panels, so if you have a PPO, Dr. Beckner would be considered an “out of network” provider. Your insurance company will determine how much you are reimbursed for her services.

**For Medicare Beneficiaries:** If you are receiving insurance coverage through Medicare or will during the course of treatment, please be aware that Dr. Beckner is not a Medicare provider. Your signature below indicates that you accept full responsibility for payment of Dr. Beckner fees. Additionally, your signature indicates that you will not submit claims to Medicare for Dr. Beckner 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)

# San Francisco Group for Evidence-Based Psychotherapy

*Victoria Lemle Beckner, Ph.D.*

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**Confidentiality & reimbursement:** 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. Beckner will include this information on your statement. In some cases, insurance companies will require that the provider send information about the patient's diagnosis and treatment plan, progress reports, and other records. Please be aware that when information is sent to an insurance company, Dr. Beckner has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Beckner cannot assure that they will do so. Some share the information they receive with a national medical information data bank for the purposes of deciding eligibility for future life, disability, health, and other insurance. Before Dr. Beckner sends any information to an insurance company, she will talk with you about what she has written and she will obtain your written permission to release the information to your insurance company. You do have a choice about whether to release the information requested by an insurance company, but if you refuse to consent to releasing it, most insurance programs will not pay for services.

**RECORD-KEEPING:** Dr. Beckner maintains a clinical chart for each client. Information in the chart includes a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Beckner also keeps records of any consent, release, assessment, insurance, or other forms completed in the course of your treatment. Clinical records are stored in electronic files, which are password protected, and hard copies are kept in a locked cabinet.

**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. Beckner 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. Beckner permission to do this, provided that she takes reasonable efforts to protect your identity.

**RESEARCH, WRITING, TEACHING:** Dr. Beckner 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. Beckner permission to use information about you and your treatment in any of these ways, provided that she takes reasonable efforts to protect your identity.

**FEES:** Dr. Beckner's fee is \$200 per 50-minute session, and you are expected to pay on the day of the session. Longer or shorter sessions are generally prorated from this base fee. Longer or shorter sessions are generally pro-rated from this fee. If you meet with Dr. Beckner on the telephone for a 50-minute session, you will be charged the standard session fee. 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. Beckner prepare paperwork for you (for example, a treatment summary for another source), she may bill for the time that this requires. She generally 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

# San Francisco Group for Evidence-Based Psychotherapy

*Victoria Lemle Beckner, Ph.D.*

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).

**IF YOU ARE INVOLVED IN LITIGATION IN WHICH YOUR EMOTIONAL STATE OR PARTICIPATION IN THERAPY MAY BE RELEVANT:** Dr. Beckner' 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 \$300/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.

**PAYMENT:** Payment is due at the time of each session unless another arrangement has been made. Dr. Beckner will provide you with a monthly statement if you request one.

**CANCELLATIONS AND MISSED APPOINTMENTS:** In order to avoid being billed for an appointment, please cancel a minimum of 48 hours prior to your appointment time. Late cancellations in the case of illness or work conflicts are not considered exceptions, but you always have the option of having a phone session, or may reschedule for another time that week (if available). Please be aware that insurance companies will not generally reimburse for a missed 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. Beckner's time, which she generally cannot use to help someone else without adequate notice.

**REIMBURSEMENT:** You are responsible for collecting reimbursement from your insurance company or other source.

**ENDING TREATMENT:** You may withdraw from treatment at any time. It is important, however, to discuss plans to terminate treatment with Dr. Beckner before taking action, so that she has an opportunity to offer her recommendations, describe any potential consequences to ending treatment at that time, and offer referral options if they are needed. If you discontinue meeting with Dr. Beckner 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.

Your signature below indicates that you have read and understood this agreement and the Patient Bill of Rights, and have had all of your questions answered. Your signature further indicates that you 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 client (please print): \_\_\_\_\_

Signature of client: \_\_\_\_\_

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