CLIENT INTAKE FORM
DATE _____

CONDITIONS FOR PSYCHOTHERAPY REQUESTS

1. Our Self-Love Recovery Program/SLRP *only treats individuals with Self-Love Deficit Disorder/SLDD (codependency),* who have been traumatized. SLRP is not a trauma treatment program.
2. Having deficiencies in self-love is not the same as being "Self-Love Deficient/Codependent." Numerous other mental health challenges include such a deficit.
3. SLRP is designed for people who fit Ross Rosenberg's definition of SLDD/codependency, as defined in his book, "The Human Magnet Syndrome." book.
4. Having read "The Human Magnet Syndrome" is **required** *prior to the first session.*
5. Acceptance into SLRP is not guaranteed. During the initial session, prospective clients are evaluated for SLDD, and if they can benefit from SLRP.
6. If not accepted, at the end of the initial session, Ross will share his evaluation and provide helpful recommendations.

NAME: _____ **DATE OF BIRTH**: _____ **AGE:** _____

ADDRESS:_____

HOME PHONE: _____ **CELL PHONE**: _____

EMAIL ADDRESS: _____ **Gender:** Male ___ Female ___

RELATIONSHIP STATUS: _____ Children? (Y/N) ___ How many? _____

EMPLOYMENT / OCCUPATION: _____

SAFE TO CALL EMERGENCY CONTACT:
Name: _____ Relationship: _____ Phone: _____

HAVE YOU READ THE 2ND EDITION OF "The Human Magnet Syndrome: The Codependent Narcissist Trap" BOOK? (Y/N) ___

IF SO, WHAT ABOUT IT WAS MOST VALUABLE?

_____
_____
_____

DESCRIBE YOUR CODEPENDENCY/SELF-LOVE DEFICIENCY: According to the Human Magnet Syndrome (book's) specific definitions, without referencing trauma.

HOW WERE YOU REFERRED?

HOW DID YOU LEARN ABOUT ROSS ROSENBERG'S WORK?

WHAT PROMPTED YOU TO SEEK ROSS'S HELP?

LIFE STRESSORS (Personal, Health, Familial, Relational, and/or Occupational):

MENTAL HEALTH HISTORY (Problems and/or diagnoses):

CURRENT OR PAST MENTAL HEALTH, PSYCHIATRIC TREATMENT:

ADDICTION AND/OR SUBSTANCE ABUSE HISTORY, INCLUDING TREATMENT:

CURRENT MEDICATIONS *related to mental health treatment*:

Medication: _____ Dose: _____ Frequency: _____ Started: _____
Medication: _____ Dose: _____ Frequency: _____ Started: _____
Medication: _____ Dose: _____ Frequency: _____ Started: _____

CREDIT CARD INFORMATION:
Number: _____ Expiration Date: _____ V. Code: _____

FEES:
Psychotherapy: $315/45-minutes. $420 for 60 minutes (prior authorization is required)
Expert Witness Consultation: $350 for 45-minutes
Report writing or any other request: $7.77 a minute – the equivalent of $350 an hour.

CANCELLATION POLICY: Without 24-hour advanced notice, or if the session was forgotten: $250

SIGNATURE OF AGREEMENT:
Signing confirms you have accurately provided all requested information and agree with the session and late-cancelation fees:

Signature: _____ **Date:** _____