Dr. Thomas L. Ryer
dr.thomasryer16@gmail.com
Port Jeff. Station, NY 11776

Transitional Life Coach Spiritual Counseling, LLC

Confidential Client Information Form

General Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work: _____ Cell:_____

Sex: M_____ F_____ Other_____ Date of Birth: _____ Age: _____

Employer: _____ Occupation/Title: _____

Hours Per Week: _____ Years at Job: _____ Highest Level of Education Completed:_____

Do you regularly attend church, synagogue or other religious institution? Yes____ No____

How did you hear about our services? _____

Relational Information:

Single ___ Engaged ___ Married ____ Separated ____ Divorced___ Widowed____

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of Spouse: _____ Spouse's Age: _____

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Please list your children including step, adopted and foster children:

Name	Sex	Age	Relationship to you	Living with Whom

Please identify any of the following you experienced in your family:

Physical Abuse: _____ Emotional Abuse: _____ Sexual Abuse: _____
Abortions_____ Gambling: _____ Drug/Alcohol: _____
Major Losses _____ Multiple Marriages: _____ Religious Upbringing: _____

Counseling History:

If you have had previous counseling, psychiatric treatment, substance abuse treatment, or residential/inpatient care please list name of programs and counselors:

Name of Program/Counselor	Issues Addressed	Dates of Services Received

Has anyone in your family been treated for substance abuse or mental health conditions? Yes _____ No _____
If Yes, please describe:
_____
_____

Have you ever attempted suicide? Yes_____ No _____
If yes, when was your last attempt?
_____

By what means did you attempt? (e.g. overdose on pills, drugs, cutting/stabbing)_____

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Has any of your family or friends ever attempted or committed suicide?
Yes ____ No____
If Yes, when _____
By what means? _____

Have you ever experienced any violent or homicidal thoughts? Yes____ No____
If Yes, please describe:
_____
_____

Medical History:

Name/Phone #of current physician: _____
Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries (and date of surgeries) that might be relevant to your reason for seeking counseling:
_____
_____

Please list current medications you are taking even if use is seldom or as needed:

Name of Medication	Dosage/Frequency	Reason for Taking Medication

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Present Issues and Goals:

Please provide reasons for seeking counseling (issues, problems, symptoms, how long, etc.)

_____

_____

Check any of the following symptoms or problems that you are currently or have recently experienced. Please indicate from 1 to 10 how distressing these problems are to you; 1 being the least amount of distress you are experiencing and 10 being the most amount of distress you are experiencing:

Loss_____	Sexual Problems_____	Loneliness_____	Indecisiveness_____
Fatigue_____	Marital Problems_____	Drug Use_____	Relational Issues_____
Aggression_____	Verbal Abuse_____	Shyness_____	Financial Issues_____
Grief_____	Sexual Addiction_____	Work Issues_____	Obsessive Thoughts_____
Voices_____	Feeling Worthless _____	Anger_____	Controlled By Others_____
Panic_____	Low Self –Esteem _____	Fears_____	Eating Problems _____
Anxiety_____	Gender Identity_____	Controlling_____	Loss of Control_____
Pregnancy_____	Career Choices_____	Apathy_____	Compulsive Behavior_____
Bad Dreams_____	Trouble Sleeping_____	Alcohol Use_____	Hearing Racing Thoughts_____
Abortion_____	Emotional Abuse_____	Chronic Pain_____	Unwanted Memories_____
Depression_____	Loss of Appetite_____	Stress_____	Spiritual Apathy_____
Sexual Abuse_____	Impulsive Behavior_____	Physical Abuse____	Poor Concentration_____

Informed Consent for Transitional Life Coaching/ Spiritual Counseling Services

I am willingly entering into a life coaching/spiritual counseling relationship with the understanding of the following conditions:

1. *I understand that my records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements, serious threats of harm to self or others) or I have signed the appropriate release forms to release my documents to myself or a third party.*

2. *Transitional Life Coaching/Spiritual Counseling will cover spiritual, emotional and physical aspects of my life and may, at times be challenging. However, I understand that working through my issues will enable me to achieve a healthier way of living.*

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3. *I have the right to ask questions pertaining to my sessions and may discontinue services at any time. I understand that terminating services is best decided after first consulting with Dr. Ryer*.

4. *I understand that Dr. Ryer **does not accept insurance** as payment for services rendered and that I will be required to pay by cash or debit/credit card.*

5. *The cost of sessions are: 50 minute individual sessions -$70; 50 minute couple sessions -$125; 90 minute group and family sessions - price will vary based on need and/or circumstance.*

6. *With the exception of emergencies, I understand that I can only cancel or reschedule my appointment at least 24 hours prior to my scheduled appointment. There will be a **charge of $50.00** if my appointment is cancelled within less than 24 hours of appointment. Cancellations can be made by phone, voicemail or email.*

7. *Please understand that Dr. Ryer is not a psychiatrist and does not diagnose or prescribe any forms of medication. Dr. Ryer is an ordained minister who provides life coaching/spiritual counseling based on faith-based perspectives. Dr. Ryer offers guidance and suggestions which may help one in their daily decision-making. Should one need additional services outside of Dr. Ryers' scope of practice, a referral will be made.*

Disclaimer: Clients understand that the use of this service is entirely of their own choice. Any actions or lack of actions taken by the client of such advice is done so solely by choice and responsibility of the client and is neither the responsibility nor liability of Dr. Ryer.

_____ _____
Client Name Date

_____ _____
Client Signature Date

_____ _____
Provider Name Date

_____ _____
Provider Signature Date