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: _____

Billing Insurance: ____ Yes ____ No If so, please provide name: _____

Marital Status: ____ Single ____ 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 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

Jeffrey Adorador, MS - Licensed Marriage Family Therapist # 80129

(Fill out only if you have a minor participating in counseling)

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)_____

_____ _____
Parent/Guardian Signature (If both are needed) *Date*

(print)_____