

**DR. JENESSA NYE  
701 E. SANTA CLARA ST., SUITE, 43  
VENTURA, CA 93001**

**CLINICAL ASSESSMENT**

**Date:** \_\_\_\_\_

**Name:**

**Birthdate/Age:**

**Address:**

**Phone Number:**

**Emergency Contact:**

**Occupation/place of work:**

**Current Stressor(s):**

**General Health (drug or alcohol use/frequency, sleep habits, exercise routine, eating habits, sexual activity, anxiety, hyperactivity, chronic pain, changes in appetite, energy, thinking, concentration, etc.)**

**History of suicidal ideation, homicidal ideation, hospitalizations, drug addiction, sexual addiction, eating disorders, arrests, legal problems, etc.**

**Family history: Parents, siblings, birth, family culture, how did family members relate, divorce/separation, sexual abuse/trauma, substance abuse, physical abuse, mental illness, etc.**

**Spiritual or religious beliefs:**

**History of meaningful long-term relationships (friends, therapists, lovers, spouses, children, parents, grandparents):**

**Current mood:**

**Overall daily mood:**

**Obstacles to Personal Growth:**

**Personal strengths:**

**Treatment goals as described by patient:**

**DR. JENESSA NYE**  
**701 E. Santa Clara St., Suite 43**  
**Ventura, CA 93001**

## **THERAPEUTIC AGREEMENT**

**Responsibilities & Payment:** Sessions are 50-minutes in length and \$225. Payment is required before or after each individual session. Therapist will provide receipts for paid sessions at the request of patient. **A 24-hour notice prior to a cancellation is required to avoid being charged the full amount.**

**Confidentiality:** All information and records obtained during the course of therapy shall be held in strictest confidence and privacy. Patient information will not be disclosed to any outside person or agency without a written consent (or, if a minor, written consent of a parent or legal guardian). Therapist may consult with colleagues and specialists about our ongoing work together in order to provide the best possible treatment. However, therapist will never disclose patients name or any specifics that may compromise identity or confidentiality.

**Confidentiality is legally allowed to be broken by law under these four circumstances:**

1. **If patient is a serious threat to harm themselves.**
2. **If patient is a serious threat to harm another person.**
3. **If patient or therapist has reasonable suspicion that a child, an elder or a dependent adult has been or will be abused or neglected.**
4. **If patient is suing someone, being sued or being charged with a crime therapist is ordered to show the court records only after a subpoena has been served.**

**Benefits of Therapy:** Patient can expect to benefit from therapy, although there is no guarantee. Maximum benefits will occur with regular attendance and with following treatment recommendations. It is possible patient may feel temporarily worse while in treatment. To provide the best possible treatment, please abstain from all non-prescription drugs and alcohol.

**If either the patient or the therapist should notice each other in a public setting/outside of the office, then the therapist will not approach the patient due to keeping the relationship confident. If the patient chooses to engage in a brief conversation or acknowledge the therapist, that will be at their discretion.**

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Print Name

Sign Name

Date