  
Licensed Clinical Social Worker  
AASECT Certified Sex Therapist & Sex Educator

[www.kristenlilla.com](http://www.kristenlilla.com)  
[www.omahasextherapy.com](http://www.omahasextherapy.com)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (402) 201-6046  
Email [kristen@kristenlilla.com](mailto:kristen@kristenlilla.com)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P.O. Box 31490 Omaha, NE 68131

FIRST APPOINTMENT PACKET

Thank you for choosing Kristen Lilla LLC for your therapeutic services. Prior to your first session, please complete the Disclosure Statement, Agreement of Services, and Client Information. This will allow Kristen Lilla time to review your client information and therapy goals. It will also give you a chance to make a list of any questions you have about therapy. Filling out these documents prior to your first session will save valuable time for both you and your therapist and allows you to immediately start working towards your goals. If you do you understand, or do not feel comfortable, answering any of the questions in this packet, Kristen would be happy to assist you during your initial session. Kristen can further assist you in answering any questions you have during your first session.

**Each individual attending therapy should fill out the following forms:**

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

Gender: □Male □Female □ Transgender □ Non-Binary □ Intersex □ Other

Pronouns: □He/Him □She/Her □ They/Them □ Other ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Sexual Orientation: □Heterosexual □Lesbian □Gay □Bisexual □Queer □Pansexual □Asexual □Other  
Relationship Status: □ Single □ In a Relationship □ Living with Partner □ Married □ Separated

□ Divorced □ Widowed □ Polyamorous □ Other

Age:\_\_\_\_\_\_\_\_ □ Minor (under 19 in NE) Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
State: \_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_

Landline: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it OK to leave a detailed message on this number? □Yes □No

Work: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it OK to leave a detailed message on this number? □Yes □No

Cell: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it OK to leave a detailed message on this number? □Yes □No

Is it OK to text you on this cellphone? □Yes □No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to contact you via this email address? □Yes □No

Primary Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education (highest level): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduation year: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their phone: Landline: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree for this person to be contacted in an emergency (initial) \_\_\_\_\_\_\_\_\_\_

**Spouse/Partner Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: □Male □Female □ Transgender □ Non-Binary □ Intersex □ Other  
Pronouns: □He/Him □She/Her □ They/Them □ Other ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Sexual Orientation: □Heterosexual □Lesbian □Gay □Bisexual □Queer □Pansexual □Asexual □Other

Age:\_\_\_\_\_\_\_\_ □ Minor (under 19 in NE) Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

State: \_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ □ Same As Above

Landline: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it OK to leave a detailed message on this number? □Yes □No

Work: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it OK to leave a detailed message on this number? □Yes □No

Cell: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it OK to leave a detailed message on this number? □Yes □No

Is it OK to text you on this cellphone? □Yes □No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to contact you via this email address? □Yes □No

Primary Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education (highest level): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduation year: \_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? □Yes □No

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any current/past medical procedures or surgeries you have had.

|  |  |  |
| --- | --- | --- |
| Procedure/Surgery | Date of procedure/surgery? | Are you still recovering? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Current Medications (Please include all over the counter medication and vitamins you take.)

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | How often do you take it? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

How would you rate your current sleeping habits? □Poor □Unsatisfactory □Satisfactory □Good

Please list any specific sleep problems you are currently experiencing:

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

How many times per week do you generally exercise (if at all)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of exercise to you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any difficulties you experience with your appetite or eating patterns:

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

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, please explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had homicidal or suicidal ideation? □ No □ Yes Most recent date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently feeling homicidal or suicidal? □ No □ Yes

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Does this pain occur during sexual activities? □ No □ Yes

How often do you drink alcohol? □ Never □ Daily □ 2-3x week □ 1x week □ 2x month □ <1x month

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never  
What drugs do you currently use?­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently masturbate? □ No □ Yes If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Do you currently look at pornography? □ No □ Yes If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been sexually assaulted? □ No □ Yes   
If yes, what age where you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who were you assaulted by?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Have you ever received counseling for this?­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Does your current partner know about the assault? □ No □ Yes □ N/A

Have you ever had an affair? □ No □ Yes Was it in your current relationship? □ No □ Yes  
Is your partner aware of your affair? □ No □ Yes Do you plan to address this in therapy? □ No □ Yes

Has your partner ever had an affair? □ No □ Yes Was it in your current relationship? □ No □ Yes   
Do you and your partner currently engage in non-monogamy? □ No □ Yes Have you ever? □ No □ Yes

Have you, or anyone in the immediate family, seen a Mental Health Professional Before? □ Yes □ No

If Yes, Please list Symptoms, Diagnosis, and Treatment received:

|  |  |  |
| --- | --- | --- |
| Person | Diagnosis | Treatment Received |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are you currently seeing a Mental Health Professional? □ Yes □ No

Therapist/Psychologist/Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_

Therapist/Psychologist/Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_

Referred By: □ Urologist □ OB-GYN □ Pelvic Floor Therapist □ Psychology Today □ Social Media

□ Internet Search (Google) □ Mental Health Therapist □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referral Person /Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the primary reason for seeking services today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

What are your goals for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

I understand that the fee for each 50-minute session will be $230 until further notice. I understand that I am assuming responsibility for payment of my bill at the time of the session, unless other arrangements are made and herein specified. I understand that it is important to provide at least 24-hours’ notice of cancellation of a scheduled appointment, and in not doing so I will be liable for a charge of $115.00 for this scheduled time. It is usual practice to provide payment for the session at the start of each session by cash, check, or credit card, however I agree for Kristen Lilla LLC to keep my credit card details on file to pay the balance of any outstanding self-pay or cancellation fees. I also understand that should the account balance remain outstanding, that Kristen Lilla LLC may utilize the services of a collection agency.

Credit cards will be kept on file with Ivy Pay, a HIPPA complaint therapy app. Unless paying by cash or check, I will receive a text at my first appointment to set up an account with Ivy Pay.

I authorize Kristen Lilla LLC to charge my account for any outstanding amounts owed.

**Cardholder’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for filling out the Intake. Please note all information is confidential. If additional information is needed after the first session, you may be asked to fill out a more comprehensive packet. If you have any further questions prior to your session, please do not hesitate to call Kristen at 402-201-6046 or email Kristen@kristenlilla.com