Wellness Counseling Services

www.wellnesscounselingmn.com
612-746-7701

CONFIDENTIAL INTAKE INFORMATION SHEET

Client Name _____ **Today's Date:** _____

Birth Date: _____ **Age:** _____ **Race / Lineage:** _____

Gender: ■ Male ❑ Female ❑ Non-binary ❑ Transgender ❑ Other **Pronoun:** _____
Explain if you choose to: _____

Home Address: _____

_____

Phone: Home (___)_____ **Cell**(___)_____ **Work**(___)_____
I give my permission to be called at:
home ❑No ❑Yes **cell** ❑No ❑Yes **work** ❑No ❑Yes
May I leave a message on voicemail? ❑ No ❑ Yes

I understand that if I have caller ID, the therapist's name will be disclosed to others. Please initial _____

E-mail*: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential

Emergency Contact Name & Relationship to Client: _____

Emergency Contact Phone #: _____

Current Occupation: _____

Employer: _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

How did you find Wellness Counseling Services (WCS)? Please place a check by the options below.

☐ **Online?** If you remember, which online listing did you use?

☐ WCS Website ☐ PsychologyToday.com ☐ Theravive.com ☐ Good Therapy.org ☐ Google

☐ **Friend/Family Member** ☐ **School** ☐ **Current or Former Client** ☐ **County**

☐ **Other** ***Name of person who referred you**_____

Presently I am (check all that apply)

☐ Single / Dating

☐ In a monogamous exclusive relationship
Note type: Married ☐ Engaged ☐ Cohabiting ☐ Living Separately ☐

☐ In non-monogamous / polyamorous relationship(s)
Note type: Married ☐ Engaged ☐ Cohabiting ☐ Living Separately ☐

☐ Separated as of _____ after _____ years of marriage/relationship.

☐ Divorced / Broken up as of _____ after _____ years of marriage/relationship.

Current Spouse or Partner(s)
Name Age (if deceased, check the box) Occupation Comments

☐ _____

☐ _____

Previous Spouse(s) or Partner(s) of Note
Name Age (if deceased, check box) Dates of Relationship Occupation Comments

☐ _____

☐ _____

My Children Name Age (if deceased, check box) Occupation Comments

#1 ☐ _____

#2 ☐ _____

#3 ☐ _____

#4 ☐ _____

Please list additional children on the back of this sheet.

Education (Check Appropriate Level)

☐ High School or Pre-GED grade _____

☐ High School/GED

☐ Some College; _____ Years

☐ B.A. - B.S.: Major Field _____

Graduate Work - Highest Degree _____ Major Field_____

Family of Origin

My Parents Name Age (if deceased, check box) Occupation Comments

Parent ☐ _____

Parent ☐ _____

Share a few words about your parents' relationship. Were they married? ☐ Yes / ☐ No
Were they divorced? ☐ Yes / ☐ No

_____

_____

Step-parents or Impactful Parental Figures (Identify relationship: ie. Step-parent on mom's side)

1._____

2. _____

3. _____

4. _____

Siblings Name Age (if deceased, check box) Occupation Comments
Begin with the oldest through the youngest; include yourself.

Sib 1 ☐ _____

Sib 2 ☐ _____

Sib 3 ☐ _____

Sib 4 ☐ _____

Sib 5 ☐ _____

Military Service (check one): ☐ **Yes** / ☐ **No If yes, list branch and deployment history:**

_____

_____

Have you had previous therapy? Where? When? Please note if the therapy was in some way harmful or problematic to you. _____

_____

Other Workers or Therapists Involved in Current Treatment (e.g. County, School, Etc.)

_____

Treatment History (past and present):

	Past	Present	When	Where	Was it helpful, unhelpful, or harmful
Counseling/ Psychiatric treatment					
Treated after Suicide Attempt(s) / Self-Harm					
Drug/Alcohol treatment					
Hospitalizations for mental health reasons					
Involvement with self-help groups					

Date of last Physical Exam _____

Have there been recent changes in your physical condition? ❑No ❑Yes **Please specify:**

_____

_____

Do you have any chronic medical ailments? Please specify and indicate the date of onset.

_____

_____

List any medications (and dosages) you are presently taking:

_____

_____

Present and Past Substance Use

Check following substances that you have used:	Amount of and Frequency of use (ie. 2 drinks daily 3 times per week)	Past or Present	I am concerned that I am using this substance too much.	My loved one is concerned I am using this substance too much.	I no longer use this substance due to past problems with it.
☐ Alcohol					
☐ Marijuana					
☐ Cocaine/Crack/Meth.					
☐ Inhalants					
☐ Stimulants					
☐ Hallucinogens					
☐ Heroin/Opiates					
☐ Prescription Drugs (if you have abused them) (specify)					
☐ Other (specify)					

Does family history include substance abuse? ☐ No ☐ Yes (describe)_____

_____

_____

_____

Client Concerns Checklist

Please check any of the following that concern you currently.

Individual Concerns

☐	Depressed mood	☐	Anxiety or panic attacks	☐	Poor self-esteem/ Body shame
☐	Crying spells	☐	Perfectionistic thinking	☐	Problems with eating
☐	Sleep difficulties	☐	Intrusive memories of past painful/ traumatic experiences	☐	Weight loss or gain
☐	Difficulties with motivation	☐	Generalized dissatisfaction	☐	Restrictive eating
☐	Irritability	☐	Confusion	☐	Binge eating
☐	Mood swings	☐	Problems with anger	☐	Health problems
☐	Suicidal thoughts	☐	Aggressive or violent behavior	☐	
☐	Self injurious behavior	☐	Unwanted behavior: habits or compulsions	☐	Muscular tension
☐	Grief/loss	☐	Trouble with memory or concentration	☐	Frequent headaches
☐	Substance use problems	☐	Struggle to organize and complete tasks	☐	Menstrual difficulties
☐	Work-related concerns	☐	Family of origin problems	☐	Financial management
☐	School-related concerns	☐	Parenting problems	☐	

Relationship Concerns

☐	Communication	☐	Conflict management	☐	Concerns with partner's substance use
☐	Lack of emotional intimacy / Closeness	☐	Escalated fighting with intimate partner	☐	Navigating relationship with our parents
☐	Struggle with sexual intimacy	☐	Feeling unsafe with intimate partner	☐	Coparenting
☐	Codependency / Overly dependent	☐	Feeling out of control with intimate partner	☐	Blending family with children
☐	Fear of intimacy / Closeness	☐	Conflict avoidance	☐	Infertility

Sexual Concerns

☐	Lower sexual desire than partner	☐	Higher sexual desire than partner	☐	Performance anxiety- "In my head about how sex is going"
☐	Partner initiates sex too often	☐	Partner doesn't initiate sex often enough	☐	Pain during sex
☐	Sex feels disconnected	☐	Feeling rejected / unwanted after initiating sex	☐	Premature ejaculation
☐	Lack of arousal/pleasure	☐	Lack of passion / Sex feels boring	☐	Cannot get or maintain erection
☐	Difficulty with Orgasm	☐	Feeling numb or disconnected from your body during sex	☐	Body feels tense, anxious, or scared before, during, and/or after sex
☐	Feeling pressured for sex and like I "should/have to" have sex	☐	Concerns with porn use	☐	Concerns with infidelity

Please note if you have experienced any of the following in your history:

☐	Sexual abuse / Sexual assault	☐	Past attempted suicide	☐	Past chemical dependency
☐	Physical abuse	☐	Past hospitalization for suicide	☐	Past treatment for substance use
☐	Physical neglect	☐	Suicide in your family	☐	Chemically dependent sibling
☐	Emotional abuse	☐	Traumatic birth experience	☐	Chemically dependent parent
☐	Emotional neglect	☐	Traumatic experience around injury, illness, or medical experiences	☐	Chemically dependent grandparent
☐	Family history of mental illness	☐	Near death experience	☐	Traumatic death of family member
☐	Experiences of discrimination or harm due to your race, ethnicity, or national origin.	☐	Experiences of discrimination or harm due to your age.	☐	Experiences of discrimination or harm due to your socioeconomic status.
☐	Experiences of discrimination or harm due to disability or health status.	☐	Experiences of discrimination or harm due to gender, gender identity, sexual orientation, or relationship status.	☐	Other experiences of discrimination or harm not listed

Please share further information about any of the experiences checked above if you choose to.

_____

Please list any severe emotional or medical problems of your parents or siblings:

Do you consider yourself to be spiritual or religious? ❑Past ❑Present **If you are currently spiritual or religious, please describe your faith or belief:**

_____

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your growth areas?

_____

_____

Please state anything else that you believe may be useful background information about yourself:

_____

_____

WELLNESS COUNSELING SERVICES
Therapeutic Contract

I/we, _____the client(s), agree to participate in therapy with Rebekah Miller for (circle one) individual/couple/family therapy at the appointment times and places we agree on, starting on (date) _____. The intake session is 60 minutes. Each session after that is 50 minutes in length.

Responsibility of the client
I agree to schedule all appointments with my therapist, arrive on time, participate in therapy, and take medications prescribed by doctors or other mental health professionals. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest.

Fees
I agree to pay $280 for my initial 60-minute intake session. I agree to pay $240 for each 50-minute session, unless another fee has been negotiated. Note alternate agreed upon fee if applicable: _____. I agree to pay at the beginning of my session. I agree to pay for appointments that I fail to attend or fail to give more than 24-hour notice of cancellation. I understand that WCS does not accept insurance payments for services. I understand that checks, cash, HSA/FSA, or credit cards are accepted forms of payments. Checks can be written out to Wellness Counseling Services and given directly to my therapist, who can provide a receipt for services when requested. I also agree to pay a $25 fee for any returned checks. I understand that failure to pay for 2 consecutive sessions will result in therapy being placed on hold until the balance on my account is paid.
*I understand that if I discontinue services and return at a later date, the fee may have increased, or the low fee slot may no longer be available.
*I understand that sliding scale and low fee slots are based on need and will be reviewed quarterly.
*I understand that fees are reviewed yearly and may be increased with a 30-day notice to the client.
Initial: _____

Cancellation
I understand that I can cancel via phone, voicemail, text, email, or in person. I agree to pay full fee for appointments that I fail to attend or fail to give more than a 24-hour notice of cancellation.
Initial: _____

Illness
I understand that I am able to late cancel a session without charge due to illness, but I will attempt to give as much notice as possible. I agree to request a telehealth session over an in-person session if I have been in close contact with a loved one who has been sick or if I am concerned that I may be getting sick.
Initial: _____

Telehealth
I understand that video or phone therapy is available, and it is my responsibility to ensure that I am in a location that allows privacy and provides good internet or phone service. **Initial**: _____

Client last names: _____

Confidentiality & Exceptions
I understand that my records are kept private, confidential, and secure. I understand that I have the right to access my records. I understand that information can only be released to a third party with a signed release. My therapist has gone over the limits of confidentiality with me, and I understand the limits of confidentiality.

Limits to Confidentiality and Mandated Reporting
The limits of confidentiality have been explained to me. I understand that I have access to the "Notice of Privacy Practices" for a complete description of the uses and disclosures of my Protected Health Information (PHI). I understand that my WCS therapist can be mandated to report or release my records, which means that under certain circumstances, she is required by law to release information without my consent. These circumstances are described below.

1. **If you make a specific threat to harm yourself or someone else (and the risk of danger is deemed imminent), your therapist must take the appropriate steps to protect you or warn the appropriate parties.**
2. **If you report the abuse or neglect of a child or vulnerable adult, your therapist must report it to the appropriate authorities.**
3. **If you are pregnant and using controlled substances (heroin, cocaine, phencyclidine, methamphetamine or their derivatives), your therapist must report it to the appropriate authorities.**
4. **Court order or subpoena for client records.**
5. **Any Ethical investigation into your therapist by the board of Marriage and Family Therapy.**

Consultation
I understand that my WCS therapist consults with other mental health professionals about clients that she is working with in therapy. I understand that my therapist will not disclose personal information about me but will share enough case information in consultation with others in order to gain helpful advice for working with me in therapy.

Informed Consent for Treatment
A copy of "WCS Informed Consent and Notice of Privacy Practices" has been offered to me. I understand its contents and agree to abide by its terms to include giving general consent for treatment. I may at any time decline specific recommendations. General consent for treatment includes evaluation, psychotherapy, involvement in treatment planning, and psychological testing (if indicated).

Concerns with Therapy
I understand that my therapist is always open to feedback and will attempt to address any of my concerns about the therapeutic process. I understand that if I have any concerns about the practice of marriage and family therapy that I do not feel comfortable discussing with my therapist, I can contact the MN Board of Marriage and Family Therapy (this process is referenced in the client bill of rights found in the WCS Informed Consent and Notice of Privacy Practices form).

Page 2 of therapeutic contract

Client last names: _____

Court involvement
I understand that if I request my therapist to appear in court on my behalf, I must give a full 60-day notice and pre-pay $5000 per day for each single appearance in court. I understand that my therapist will not testify regarding who is at fault in a divorce, and my therapist will not make recommendations about custody, as both are outside of the scope of practice.

Ending Therapy
I understand that the length of therapy is dependent upon my needs as the client and that ending therapy is a collaborative process between the therapist and client. I understand that I can request to end therapy at any time, due to achievement of goals, desire to be referred to another professional or specialist, or any other reason. I understand that therapy will end and my case will be suspended or clinically closed if I fail to attend 3 scheduled appointments in a row without proper cancellation, have not attended therapy for 30 days, or have not paid my fee for 2 consecutive sessions. In these circumstances, my therapist will make a reasonable attempt to notify me that my case is being suspended or closed via phone and/or email. I understand that I can request for my therapist to give me referrals for services. I understand that I can request for my case to be reopened in order to resume services.

Signature indicates acceptance and agreement of the above stated WCS policies and practices.

I have received and understand the contents of this therapeutic contract, the WCS Informed Consent, and the Notice of Privacy Practices. I give my consent to treatment.

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

I have discussed the issues above with the client(s).

_____ _____
Signature of therapist Date

Page 3 of therapeutic contract

Client last names: _____

WCS Couples Confidentiality Statement

About couples therapy
Couples therapy is a distinct form of therapy. The treatment unit is the relationship, and not the individuals. It is common in couples therapy that both partners will experience different levels of agreement and disagreement with the therapist. The goal is to change and improve the relationship, by helping the couple become a "team against the problem" and by empowering the individual to change their role and reactivity in their relationship patterns and cycles. To support this goal, couples therapy will include individual sessions as part of supporting relational change. **Initial**: _____

Secrets, privacy, and confidentiality
Due to the nature of couples therapy, your therapist maintains a "no secrets" policy. A "no secrets" policy means that information obtained by the therapist in any manner is to be used to foster the therapeutic process. WCS, in general, does not believe that secrets in couples therapy are helpful. Individual sessions are part of the couples therapy process. Both partners are offered privacy in their individual sessions, with the understanding that what is learned in those sessions will be used to better help the couple. Both partners agree to have their couples therapy discussed in individual sessions.

There are times when one partner shares a "secret" with the therapist that they are unwilling to disclose to their partner. Your therapist will use professional discretion in assessing whether this is information will harm the therapeutic process. If failure to share the information will negatively impact the couples therapy, your therapist may need to put therapy on hold or end therapy as a result. **Initial**: _____

Since the couple is the treatment unit, all consent and confidentiality resides with both partners. Specifically, both partners participating in treatment are required to sign all releases of information and to mutually agree to the treatment. If one partner chooses not to sign or give consent, information will not be released from the file except for when required by law. **Initial**: _____

Respecting couples therapy confidentiality in the event of relationship dissolution
The focus of couples therapy is the couple. Therefore your therapist will have no opinion on matters outside of that scope. Specifically, your therapist will make no recommendations on parenting or who may be at fault if a couple chooses to end their relationship. The choice to end a relationship is a serious matter and resides solely with the couple, and needs to be made with great care and caution. Both partners agree to do everything in their power to allow the couples therapy to remain confidential. Both partners agree not to use legal means in an attempt to obtain files from couples therapy to win a legal argument in a breakup or divorce process. **Initial**: _____

I am attending couples therapy with (Name of Partner) _____ and agree to the couples confidentiality statement. By signing this form, I acknowledge that I understand this statement.

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

_____ _____
Printed Name and Signature(s) of client(s) or guardian(s) Date

_____ _____
Signature of Therapist Date