Wellness Counseling Services

www.wellnesscounselingmn.com
612-999-1169

CONFIDENTIAL INTAKE INFORMATION SHEET

Client Name ____ **Date:** _________

Birth Date: _____________________ **Age:** _______ ❑ Male ❑ Female
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: ____
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

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_____________________

Presently I am (check one)
____ Single
____ Engaged
____ Cohabiting for _____ years.
____ Married for _____ years.
____ Separated as of ___________________ after _____ years of marriage.
____ Divorced as of ___________________ after _____ years of marriage.

Current Spouse or Partner
Name Age (if deceased, circle age) Occupation Comments
____

Previous Spouse(s)
_____ Divorced as of __________________ after ______ years of marriage.
Name Age (if deceased, circle age) Dates of Marriage Occupation Comments

My Children Name Age (if deceased, circle age) Occupation Comments
#1
#2
#3
#4

Please list additional children on the back of this sheet.

Family of Origin

My Parents Name Age (if deceased, circle age) Occupation Comments
Mother
Father
Share a few words about your parents' marriage.

Siblings Name Age (if deceased, circle age) Occupation Comments
Begin with the oldest through the youngest; include yourself.
Sib 1
Sib 2
Sib 3
Sib 4
Sib 5

Please list additional siblings on the back of this sheet.
Military Service (circle 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 with the Family (e.g. County, School, Etc.)

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:

Client Concerns Checklist

Please check any of the following that concern you:

___Depressed mood
___Crying spells
___Sleep difficulties
__Difficulties with motivation
___Irritability
___Mood swings
___Weight loss or gain
___Anxiety or panic attacks
___Perfectionistic thinking
___Problems with eating
___Unwanted behavior: habits or compulsions
___Problems with anger
___Aggressive or violent behavior
___Suicidal thoughts
___Self injurious behavior
___ Grief/loss
___Substance use problems
___Concerns with partner's substance use
___Trouble with memory or concentration
___Generalized dissatisfaction
___Confusion
___Unusual thoughts
___Relationship problems
___Sexual concerns
___ Problems with coworkers
___Parenting problems
___Work related concerns
___Problems with school
___Family of origin problems
___Money management
___Physical problems
___Muscular tension
___Frequent headaches
___Menstrual difficulties
___Infertility
___Health problems
___Codependency
___Other (specify below)

Do you have any of these issues in your history:

___Sexual abuse
___Physical abuse
___Physical neglect
___Emotional abuse
___Emotional neglect
___Family history of mental illness
___Traumatic death of family member
___Past attempted suicide
___Suicide in your family
___Past chemical dependency
___Chemically dependent sibling
___ Chemically dependent parent
___Chemically dependent grandparent
___Near death experience
___Past hospitalization for suicide? When? ____
___Past treatment for substance use? When?: ____

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

____
____

Do you consider yourself to be spiritual or religious? ❑No ❑Yes **If yes, 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:

____
____

For Parents/Guardians of Minors to Complete

****

Parent Name ____ **Date:** _________
Home Address: ____

____

Phone: Home (___)___________ **Cell**(___)___________ **Work**(___)_____________

I give my permission to be called at:

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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

If second parent is involved in therapy:

Parent Name ____ **Date:** _________
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

WELLNESS COUNSELING SERVICES

THERAPEUTIC CONTRACT

I/we, ____the client(s), agree to participate in therapy with __________________________________, for (circle one) individual/couple/family therapy at the appointment times and places we agree on, starting on (date) ___/___/___. Each session 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 $ _______ per session. 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 payment 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.

Cancellation
I understand that I can cancel via phone, voicemail, text, email, or in person.

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.

Confidentiality & Exceptions
I understand that my records are kept private, confidential and secure. I understand that information can only be released to a third party with a signed release, with the exception of the limits of confidentiality as described in the Notice of Privacy Practices and the Information About Psychological Services at WCS form. My therapist has gone over the limits of confidentiality with me, and I understand the limits of confidentiality as detailed in the WCS Informed Consent and Notice of Privacy Practices form. I understand that I have the right to access my records.

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.

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).

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

WELLNESS COUNSELING SERVICES

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 substance (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.**

AUTHORIZATION FOR THE TREATMENT OF MINORS OR PERSONS UNDER GUARDIANSHIP

I authorize WCS to provide mental health services and/or treatment to my child or person for whom I am guardian.

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).

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

____ ____________
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

____ ____________
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WELLNESS COUNSELING SERVICES

COUPLES CONFIDENTIALITY STATEMENT

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, not necessarily the individual, although individual change may occur. 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.

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.

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 in a fashion that fosters the therapeutic process. WCS, in general, does not believe that secrets in couples therapy are helpful. The decision to share information that is deemed important to couples therapy will rest with the therapist and not the individual members of the couple. 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.

By signing this form, you acknowledge that you 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