Wellness Counseling Services

www.wellnesscounselingmn.com
612-999-1169

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, circle age) Occupation Comments
____
____

Previous Spouse(s) or Partner(s) of Note
Name Age (if deceased, circle age) Dates of Relationship 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.

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, circle age) Occupation Comments
Parent____
Parent____

Share a few words about your parents' relationship. Were they married? Y / N Were they divorced? Y / N

____

____

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

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 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		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 $240 for my initial 60 minute intake session. I agree to pay $190 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: _________

Page 1 of therapeutic contract
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 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.**

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

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