Wellness Counseling Services

www.wellnesscounselingmn.com
612-999-1169

CONFIDENTIAL INTAKE INFORMATION SHEET

Client Name _____ **Date:** _____
Birth Date: _____ **Age:** _____ **Preferred Pronoun:** _____
Gender: ❑ Male ❑ Female ❑ Non-binary / Other- 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:

For Parents/Guardians of Minors to Complete

****

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

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.
*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: _____

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

_____ _____

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

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. Individual sessions are often part of the couples therapy process. Both partners are offered privacy in their individual sessions, with the understanding that what is learned in those session 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.

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