Couples Intake Paperwork

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***To be completed individually*

Name_____Date Competed_____

Presenting Problem

Please describe what brings you in today:_____

_____

How long have you been experiencing this problem? __ Less than 30 days __1-6 months __1-5 years __5+ years
Rate the intensity of this problem from 1 to 5 (1 being mild, 5 being severe):____
How is the problem interfering with your day to day functioning?_____

_____

Have you or your spouse experienced any of the following symptoms in the last 30 days?:

Condition	***Myself***	***Partner***	*Condition*	*M*	*P*	*Condition*	*M*	*P*
Cries			Procrastinates			Is verbally abusive		
Has difficulty at work			Behaves aggressively			Worries		
Behaves impulsively			Behaves compulsively			Overeats		
Is lazy			Spends too much time online			Is a perfectionist		
Has sleep problems			Not a great listener			Uses pornography		
Is suicidal			Is depressed			Loses control		
Type “A” personality			Uses drugs			Uses alcohol		
Withdraws from others			Has insomnia			Distracted from relationship		
Has low self-esteem			Takes risks			Spends too much time with friends		
Overwork			Smokes			Participates excessively in: _____		
Is physically abusive			Threatens suicide			_		

Mental Health Information

Have you ever been in counseling/therapy before? _____ When? _____
If yes, did you find it helpful or effective? _____
Are you currently receiving mental health services? If yes, please list name of practitioner and type of services you are receiving: _____
Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed?

_____

_____

Have you ever or are you currently engaging in self-harm? (please circle) Currently Past
Have you ever or are you currently contemplating suicide? Currently Past
Have you ever or are you currently contemplating harming another person? Currently Past
Have you ever attempted suicide? If yes, please fill out 'Other' and include date(s), method(s), and age at time of attempt (please circle): Yes No Other:_____
Do you have a history of abuse/neglect (*please explain)*:_____

_____

Education

Education Level *(please check highest level completed):* ☐None ☐K-5 ☐6-8 ☐9-12 ☐GED ☐College Degree ☐Graduate Degree
If still attending, current school/grade:_____ Vocational School/Skill Area:_____
College/Graduate School – Years Completed/Major: _____

Employment

Are you currently employed? *(please circle)* Yes No
Current Employer:_____ Profession: _____
If you have worked in the past, what did you do for work?_____
_____

Medical Information

Who is your Primary Care Physician?_____ Phone #:_____
Primary Care Physician's Practice Name/City: _____
Are there any health problems that you experience? _____
Please list any prescription medications you are currently taking, what they are for, and dosage:_____
_____
_____
Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:_____
_____
_____

Strengths/Concerns

What concerns do you have about in your relationship?:_____
_____
_____
What concerns do you have about your partner in your relationship?_____
_____
_____
What concerns do you have about yourself in your relationship?_____
_____
_____
What are the issues that cause conflict in your relationship?:_____
_____
_____
What do you see as your strengths as a couple?:_____
_____
_____
What do you see as your own strengths?_____
_____
_____
What do you see as your partner's strengths?_____
_____
_____
What do you enjoy doing together? _____
_____
_____
What community involvement(s) do you currently have? (ie groups, clubs, activities, religious affiliation)?:_____
_____

Thank you for providing this information. It will greatly assist me in our work together.

Acknowledgment of Disclosure Statement

By signing this document, I confirm that I have received a copy of the required disclosure information, and that I have read and understood this information. I agree to participate in and/or have my child(ren) participate in counseling from Heather A. Astill, LCSW-C, MSW. This agreement shall remain in effect until either the client or the therapist, or both terminate treatment.

_____	_____	_____
Printed Client Name	Client/Legal Guardian Signature	Date

_____	_____
Heather A. Astill, LSCSW	Date

Fee Agreement

I, agree to pay the fees as stated in the disclosure statement. (Most commonly: $140 for intake/60 minute sessions and $120 for 45-50 minute sessions).

Late cancellations (less than 24 hours notice unless it is an emergency) and “no-shows” will be billed as half the session fee, and must be paid at the next scheduled appointment or within 15 days, whichever comes first. This will not be billed to your insurance.

I understand that payment is to be made at each session unless other arrangements have been made. Teletherapy sessions are billed at the same rate as office sessions. I also understand that I will be billed $20.00 for checks returned for insufficient funds.

_____	_____	_____
Printed Client Name	Client Signature	Date

_____	_____
Heather A. Astill, LSCSW	Date

Patient-Therapist Confidentiality and the Limits to Confidentiality

Patient confidentiality is a vital component of psychotherapy. It is extremely important that patients feel secure that what they discuss in therapy will not be shared. There are three circumstances in which a therapist is required to report confidential information to state public welfare officials:

1. Child abuse
2. Physical abuse of an elder or dependent adult living in the home
3. Expressed intent to harm oneself or another person

I have read, understand and agree to the terms stated herein.

_____	_____	_____
Printed Client Name	Client Signature	Date

_____	_____
Heather A. Astill, LSCSW	Date