

# Journey to Truth Counseling

## ADULT / COUPLE INTAKE FORM

(Please Print)

Date:        /        /	Social Security #	Date of birth:	Age:
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss. <input type="checkbox"/> Dr. <input type="checkbox"/> Rev.	Full Name (Last)	(First)	(Middle)
Parent/Guardian/Power of Attorney: (if applicable)	Name You Prefer:	Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other: <input type="checkbox"/> Hispanic	
<b>CONTACT INFORMATION</b>			
Street address:		Suite/Apartment Number:	
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone:	(        )	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobile Phone:	(        )	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:	(        )	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:		May We Send Email Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>EMERGENCY CONTACT</b>			
Name:		Relationship:	
Home Phone: (        )		Mobile Phone: (        )	

# Journey to Truth Counseling

EMPLOYMENT INFORMATION		
Employer:	Length of Employment:	
Occupation:	Average Hours Worked Per Week:	
Average Annual Salary: <input type="checkbox"/> \$0 to \$10,000 <input type="checkbox"/> \$10,001 to \$20,000 <input type="checkbox"/> \$20,001 to \$40,000 <input type="checkbox"/> \$40,001 to \$50,000 <input type="checkbox"/> \$50,001 to \$60,000 <input type="checkbox"/> \$60,001 to \$80,000 <input type="checkbox"/> \$80,001 to \$100,000 <input type="checkbox"/> More than \$100,000		
EDUCATIONAL INFORMATION		
( <i>Circle</i> ) Last Year of School Completed:   9   10   11   12   GED	College:   1   2   3   4	Other: _____ _____
Are You Currently in School? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, What School: _____	
RELATIONAL INFORMATION		
Current Status:  <input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living together	Are You Content with Your Current Status? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Briefly Explain: _____	
If Married, How Long: _____      Number of Previous Marriages for You: _____      For Your Partner: _____ If Separated or Divorced, How Long: _____      If Widowed, How Long: _____ Who will be attending therapy: _____		
Partner's Name ( <i>Last, First, Middle</i> ): _____	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Rev.
How long Have You Known Your Partner: _____	Age: _____	Preferred Name: _____

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## Relational Information *continued...*

Partner's Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:	Partner's Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Partner's Occupation:  Average Hours Worked Per Week:
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(Circle) Last Year of School Partner Completed: 9 10 11 12 GED	College: 1 2 3 4	Other:
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What Words Would You Use to Describe Your Partner:

Is Your Partner Supportive of You Seeking Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Partner Doesn't Know  Who will be attending therapy?	With Whom Do You Currently Live ( <i>Check All that Apply</i> ):  <input type="checkbox"/> Alone <input type="checkbox"/> Girlfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Boyfriend <input type="checkbox"/> Children <input type="checkbox"/> Roommate <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Other: <input type="checkbox"/> Parent(s)
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## CHILDREN

*List each one (Living or Deceased):*

Name	Sex	Current Age or Year of Death	Relationship to You <small>Natural, Adopted, Step</small>	Living with You?	Describe Him / Her

Have You Ever Placed a Child for Adoption:     Yes     No

If Yes, When:

Have You Ever Had a Miscarriage or Medical Abortion:     Yes     No

If Yes, When:

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## FAMILY OF ORIGIN INFORMATION

List: Mother, Father, Brothers, Sisters, Step Family, & Any Other Family Members who Affected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him / Her

## PRIMARY PHYSICIAN INFORMATION

Primary Physician: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Specialty *(eg: Family Practice, OB/GYN, Internal Medicine, etc.):* \_\_\_\_\_

Are You Currently Receiving Medical Treatment:  Yes  No    If Yes, Please Specify: \_\_\_\_\_

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): \_\_\_\_\_

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## CURRENT MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (*Use Back if Necessary*):

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  Improves  Prevents  Controls:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  Improves  Prevents  Controls:

Are You Taking these Medication(s) According to Your Doctor's Recommendations:  Yes  No

If No, Briefly Explain: \_\_\_\_\_

## PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Stomach Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Visual Trouble----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble Relaxing..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Weakness----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Rapid Heart Rate..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty Breathing----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Intestinal Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Change in Appetite----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Hearing Voices----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present

Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_ How has Your Weight Change in the Last 2-3 Months: \_\_\_\_\_

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## CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You:

Stress..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Nervousness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Anxiety ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Panic ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Unhappiness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Depression ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Guilt..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Apathy..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Terminal Illness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Death ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Grief ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hopelessness..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Inferiority Feelings ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Defective Feelings ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Loneliness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Shyness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Fears ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Friends ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Marriage..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Communication..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Physical Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Temper..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Anger..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Aggressiveness ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Bad Dreams ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Concentration ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Racing Thoughts ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Unwanted Thoughts ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Memory ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Loss of Control ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Impulsive Behavior ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Self-Control ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Compulsivity..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Sexual Problems ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Pregnancy ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Abortion..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Legal Matters..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trauma..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Eating Problems ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Drug Use ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Alcohol Use ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble with Job ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Career Choices ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Ambition ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Making Decisions ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Children..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Being a Parent..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Finances..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Loss ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Disaster ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Smoke Cigarettes ..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Self-Harm ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hi Risk Behavior ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Zoning/blanking out .... <input type="checkbox"/> Past <input type="checkbox"/> Present
Emotional Abuse ..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Verbal Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Sexual Abuse ..... <input type="checkbox"/> Past <input type="checkbox"/> Present

## LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):

1            2            3            4            5            6            7            8            9            10

Are You Currently Having Any Suicidal Thoughts?    Yes  No                                  Have You Had Them in the Past?             Yes  No

Have You Ever Attempted Suicide:         Yes  No    If Yes, When and How:

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes, When and Who:

# Journey to Truth Counseling

## PRESENTING ISSUES AND GOALS FOR THERAPY

Please Describe Why You Are Coming to Therapy (i.e. What Are Your Issues, Problems?):

Why Have You Decided to Come for Therapy Now:

What Do You Hope to Gain or Change by Coming for Therapy:

How Long Do You Believe Therapy Should Last:

## PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (*Use Back If Necessary*):

Therapist:

Reason for treatment:

Location:

Approximate Dates:

## RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

Do you attend church? If so, where? \_\_\_\_\_

Would you like spiritual principles incorporated into your therapy? Yes No

## TERMS OF SERVICE

*I hereby give Journey to Truth Counseling permission to provide biblical counseling for the person(s) mentioned above:*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Journey to Truth Counseling

## Emergency Information

We strive to return all calls in a timely manner. If you have an emergency after office hours, please call 911 or go to the nearest emergency room.

Emergency Services:	911
Greenville Memorial Hospital Info Line:	(864) 455-7000
Greenville Mental Health Crisis Line:	(864) 241-1040
Greenville Rape Crisis and Child Abuse	(864) 467-3633
Greer Mental Health	(866) 949-1319
Shepherd's Gate Women's Shelter	(864) 268-5589
SAFE Homes Rape Crisis	(864) 583-9803
Suicide Prevention Hotline	(864) 271-8888

**KEEP FOR YOUR RECORDS**



# Journey to Truth Counseling

## Payment Policy

Please read the policy and sign in the space provided and we will discuss any concerns during your appointment. A copy will be provided to you upon request.

### Insurance.

I do not currently accept insurance. All fees are due at the time of service.

Please review the following fee schedule:

Initial assessment: 75.00

One 50 minute session of therapy online: 75.00

### Nonpayment.

If a session is not paid for at the time of service, the next session will not begin until payment is made, unless prior financial arrangements have been agreed upon by the client and therapist.

### Missed appointments.

There is no financial penalty for missed appointments. However, I ask for the courtesy of letting me know at least 1 hour before your scheduled appointment that you will be unable to meet.

### Refund.

Journey to Truth Counseling does not issue any refunds for services rendered. Any disputes will be reviewed on a case-by-case basis. Prepaid plans will be refunded at a prorated rate minus any other fees incurred.

### Payment methods accepted:

Check or Money Order (must be prepayent for at least 4 sessions).

Payment via a major credit card, processed by Paypal.

Payment via Paypal, sent to the email address provided by the therapist.

Payment via "VENMO"

Payment via "SQUARE" Payments

\*Other: (as decided upon by the therapist and the client)

\*Cash is not accepted for online therapy services.

It is understood that at times financial hardships arise and it may be necessary to discontinue therapy for a season. However, it is our policy to work within our clients financial means in order to support the therapeutic process. Should your fee for service become a financial hardship for you, please discuss this with your therapist. As is the policy of the State of South Carolina and included in the AAMFT code of ethics, Marriage and Family Therapists are prohibited from bartering for service.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_