

Journey to Truth Counseling

ADULT / COUPLE INTAKE FORM

(Please Print)

Date: / /	Social Security #	Date of birth:	Age:	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <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"/> Black <input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian <input type="checkbox"/> Other:	
CONTACT INFORMATION				
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	
EMERGENCY CONTACT				
Name:	Relationship:			
Home Phone: ()	Mobile Phone: ()			

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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"/> _____ <input type="checkbox"/> Separated <input type="checkbox"/> Part <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"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss. <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:

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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 online counseling services 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.

Fee Schedule

Please review the following fee schedule:

Initial assessment (90-minutes): 85.00 *(unless a different rate is negotiated)*

(1) 50-minute session of therapy online: 85.00 *(unless a different rate is negotiated)*

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. When nonpayment reaches 3 sessions, services will be terminated until arrangements have been made to pay all unpaid sessions.

Missed appointments without sufficient notice/No Shows

There is a \$25.00 fee for missed appointments without 24-hour notice.

Rescheduling your appointment is free the first time. Rescheduling appointments more than once will constitute a "missed appointment" and will incur a \$25.00 fee. If you notify your therapist at least 24-hours in advance, there will be no fee for missing or rescheduling appointments. All instances are case-by-case and will be decided upon by the therapist.

Refund Policy

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:

Payment via a major credit card, processed by "SQUARE"

Payment via PayPal. *(Payment link/email address provided by the therapist).*

Payment via "VENMO"

Payment via "CASH APP"

Payment via "SQUARE" or "PayPal" Invoicing

*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 try to work within a client's 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: _____