Journey to Truth Counseling

ADULT / COUPLE INTAKE FORM

(Please Print)

Date: / /	Social Security #	Date of birth:	Age:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss. ❑ Dr. ❑Rev.	Full Name *(Last)*	(First)	(Middle)

Parent/Guardian/Power of Attorney: (if applicable)	Name You Prefer:	Race: ❑ White ❑Asian ❑ Black ❑ Other: ❑ Hispanic

CONTACT INFORMATION

Street address:	Suite/Apartment Number:

City:	State:	ZIP Code:	May We Send Mail Here: ❑Yes ❑No

Mailing Address or Post Office Box:

City:	State:	ZIP Code:	May We Send Mail Here: ❑Yes ❑No

Home Phone:	( )	May We Leave a Message Here: ❑Yes ❑No
Mobile Phone:	( )	May We Leave a Message Here: ❑Yes ❑No
Work Phone:	( )	May We Leave a Message Here: ❑Yes ❑No
Email Address:		May We Send Email Here: ❑Yes ❑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:

❑$0 to $10,000 ❑$10,001 to $20,000 ❑$20,001 to $40,000 ❑$40,001 to $50,000

❑$50,001 to $60,000 ❑$60,001 to $80,000 ❑$80,001 to $100,000 ❑More than $100,000

EDUCATIONAL INFORMATION

(Circle) Last Year of School Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: ______

Are You Currently in School? ❑Yes ❑No	If Yes, What School:

RELATIONAL INFORMATION

Current Status:

❑ Single ❑Dating
❑ Engaged ❑Married
❑ Separated ❑Divorced
❑ Widowed ❑Living together

Are You Content with Your Current Status? ❑Yes ❑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 *(Last, First, Middle)*:	❑ Mr. ❑ Ms. ❑ Miss.	❑ Mrs. ❑ Dr. ❑ Rev.

How long Have You Known Your Partner:	Age:	Preferred Name:

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Relational Information *continued…*

Partner's Race:

❑ White ❑Asian
❑ Black ❑ Hispanic
❑ Other:

Partner's Sex:

❑ M ❑ F

Partner's Occupation:

Average Hours Worked Per Week:

(Circle) Last Year of School Partner Completed: 9 10 11 12 GED

College: 1 2 3 4

Other:

What Words Would You Use to Describe Your Partner:

Is Your Partner Supportive of You Seeking Therapy:

❑ Yes ❑ No ❑ Unsure ❑ Partner Doesn't Know

Who will be attending therapy?

With Whom Do You Currently Live *(Check All that Apply)*:

❑ Alone ❑ Girlfriend
❑ Spouse ❑ Boyfriend
❑ Children ❑ Roommate
❑ Sibling(s) ❑ Other:
❑ Parent(s)

CHILDREN

List each one (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *Natural, Adopted, Step*	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 *(Mom, Dad, Sibling, Step)*	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------------------------- ❑ Past ❑ Present
Visual Trouble--------------------- ❑ Past ❑ Present
Weakness -------------------------- ❑ Past ❑ Present
Difficulty Breathing--------------- ❑ Past ❑ Present
Change in Appetite -------------- ❑ Past ❑ Present
Hearing Voices-------------------- ❑ Past ❑ Present

Dizziness .... ❑ Past ❑ Present
Sleep Trouble .... ❑ Past ❑ Present
Tension .... ❑ Past ❑ Present
Intestinal Trouble .... ❑ Past ❑ Present
Tiredness.................... ❑ Past ❑ Present
Seeing Things............. ❑ Past ❑ Present

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

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

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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: 150.00 ***(unless a different rate is negotiated)***
(1) 50-minute session of therapy for individuals: 120.00 ***(unless a different rate is negotiated)***
(1) 50-minute session of therapy for couple: 120.00 ***(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 / No Shows

- **There is a $25.00 fee for missed appointments without 24-hour notice.**
- **If you notify your therapist at least 24-hours in advance, and reschedule, there will be no fee.**
  - **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.**

Cancelling your appointment less than 24-hours before your scheduled time will result in a "missed appointment fee" of $25.00. All situations will be handled in a case-by-case manner, making room for the unexpected and emergencies are taken into consideration.

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:

- **Major credit card, processed through Square Payments**
- **PayPal** ***(payment link/email address provided by therapist)***
- **Venmo** ***(payment link/ @Venmo name provided by therapist)***
- **Cash App**
- **Invoicing through Square or PayPal**
- **Cash** ***(not accepted for online sessions)***
- **No Checks**

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: ______________