Santa Fe Sage Counseling Center

Couple/Family Client Intake

Date:____________________

Names:___________________________________ Partner/Parent/Child (circle one)

_____________________________________ Partner/Parent/Child (circle one)

_____________________________________ Parent/Child (circle one)

_____________________________________ Parent/Child (circle one)

_____________________________________ Parent/Child (circle one)

Insurance ID #:_________________________ Group #:________________________

Name of Company providing Insurance (if applicable):__________________________

Santa Fe Sage Counseling Center

Client Policy Statement

The fee for a one-hour session is _______. Payment is expected at time of service. In the event **you** are filing insurance claims, receipts will be provided at the end of the month. Treatment may be suspended for lack of payment.

Clients have a right to expect that information revealed in sessions not be disclosed without extraordinary justification.

The conditions that justify release of information and by law must be reported to the appropriate agencies are the following:

1. Knowledge of child abuse or neglect.
2. Knowledge of senior citizen abuse or neglect.
3. A client poses a serious risk of suicide and is an imminent danger to self.
4. A client poses a threat of imminent danger to another person.
5. Judge, by issuance of a court order, may obtain information.

In all other situations a signed authorization for release of information is required.

Your appointment is reserved for you. Missed appointments are charged for at the rate of your sessions unless cancellation is received 24 hours in advance. Insurance may not be billed for missed appointments. Emergencies are not charged for such as illness or accident. If you need clarification of what constitute an emergency please discuss this with your therapist.

Telephone calls are often necessary in the practice of psychotherapy. Phone calls are not charged for unless they exceed 15 minutes. In the case that therapy is conducted over the phone, the session will be charged for at the regular session rate on a pro-rated basis.

I have read and understand the above stated policy statement and agree to enter treatment on these terms.

_________________________________ __________________
Signature Date

_________________________________ __________________
Signature Date

_________________________________ __________________
Therapist's Signature Date

Santa Fe Sage Counseling Center

Individual Data for ___________________________________
(name)

Address:____ Zip______________

Res. Phone:_________________ Bus.:_________________ Cell:__________________

Email Address:____

Date of Birth:________________ Age:_________ SS#:___________________________

Emergency Contact Person:____________________________ Phone:_______________

How did you hear of this **Counselor** or of **Santa Fe Sage Counseling Center?________**
____

Counseling History:

Reasons for coming to counseling at this time:__________________________________
____

How long have you had this problem?____

Are you currently receiving other counseling services? _____Yes _______ No
If yes, please describe____

Have you had any previous counseling or psychiatric care? _____ Yes _______ No
If yes, what was the outcome?____

Did you receive a diagnosis? _____ Yes ______ No
If yes, what was the diagnosis?____

Who do you consider to be in your support system?______________________________
____

Other Issues You May Want to Address:____
____

____________________________________ ____________________________________
Client Name Therapists Signature Date

Santa Fe Sage Counseling Center

Individual Behaviors and Symptoms for _________________________

Check the **behaviors** and **symptoms** which cause significant impairment in **your** life now. Put ***initials*** beside the behaviors and symptoms that *you perceive as problematic in the life of any other family member participating in therapy with you.*

____Aggression	____Fatigue	____Panic Attacks
____Alcohol Dependence	____Fear of Failure	____Paranoid Thoughts
____Anger	____Feeling Numb	____Phobias / Fears
____Antisocial Behavior	____Hallucinations	____Ritual Behavior
____Anxiety	____Headaches/Migraines	____Seizures
____Appetite Change	____Hearing Voices	____Sexual Difficulties
____Avoiding People	____Heart Palpitations	____Sick Often
____Chest Pain	____Hopelessness	____Sleeping Problems
____Cleaning	____Impulsiveness	____Speech Problems
____Concentration Prob.	____Irritability	____Suicidal Problems
____Depression	____Judgment Errors	____Suicidal Plan
____Disorientation	____Loneliness	____Thoughts Disorganized
____Distractibility	____Loss of Pleasure	____Thoughts of Harming Others
____Dizziness	____Low Self-Esteem	
____Drug Dependence	____Memory Impairment	____Trembling
____Eating Disorder	____Mood Shifts	____Withdrawing
____Elevated Mood	____Motivation Problems	____Worrying

Which behaviors and attitudes, or symptoms would you like to address in your therapy?

____
____
____
____

Please indicate below your current level of commitment to being in therapy and working on the issues in your relationship(s):

1	2	3	4	5	6	7	8	9	10
Don't want to be here →	→	→	→	→	→	→	→	→ Glad to be here and ready to work	

____________________________ ______________________________
Client Name Therapist Signature Date

Santa Fe Sage Counseling Center

<u>Household and Relationship History</u>

Who lives in your household?

Name	Age	Relationship

Who are the important family members living in other households?

____
____
____
____
____

Present Marital Status:

____ 1.) never married	____ 5.) separated
____ 2.) engaged to be married	____ 6.) divorced and not remarried
____ 3.) married now for the first time	____ 7.) widowed and not remarried
____ 4.) married again	____ 8.) other (specify)_______________

If married are you presently living with your spouse? ____ Yes ____ No
If married, years married to present spouse___________________
If not married but in a long term relationship, how long?_____________________

Past Marriages or long term relationships:____
____
____

Have you ever been a victim of domestic violence? ____Yes ____ No
If yes, please explain:____
____

______________________________ ______________________________

Client Name Therapist Signature Date

Santa Fe Sage Counseling Center

Family History for ______________________
(name)

Which of the following best describes the family in which you grew up? **Please circle the appropriate number.**

HOSTILE AND FIGHTING						WARM AND ACCEPTING	
1	2	3	4	5	6	7	8

YOUR MOTHER (OR MOTHER SUBSTITUTE)
Briefly describe your mother (or mother substitute):______________________________

____

Your mother's occupation when you were a child:________________________________

____ Stayed home ____ Worked outside part-time ____ Worked outside full-time

How do you get along with your mother now? ____ Poorly ____ Average ____ Well

Did your mother have any problems (e.g., alcoholism, violence, etc.)? ____Yes ____No

If **YES**, please describe:____

Describe overall how your mother treated the following people as you were growing up:

(Circle one answer for each)

YOUR MOTHER'S TREATMENT TO:	Poor		Average		Excellent		
YOU	1	2	3	4	5	6	7
YOUR FAMILY	1	2	3	4	5	6	7
YOUR FATHER	1	2	3	4	5	6	7

YOUR FATHER (OR FATHER SUBSTITUTE)
Briefly describe your father (or father substitute):________________________________

____

Your father's occupation when you were a child:________________________________

____ Stayed home ____ Worked outside part-time ____Worked outside full-time

How do you get along with your father now? ____ Poorly ____ Average ____ Well

Did your father have any problems (e.g., alcoholism, violence, etc.)? ____Yes ____No

If **YES**, please describe:____

Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

YOUR FATHER'S TREATMENT TO:	Poor		Average		Excellent		
YOU	1	2	3	4	5	6	7
YOUR FAMILY	1	2	3	4	5	6	7
YOUR MOTHER	1	2	3	4	5	6	7

____

______________________________ ______________________________

Client Name Therapist Signature Date

Santa Fe Sage Counseling Center

Education / Work ________________________
(name)

Please check your highest level of education.

___High School ____ Undergraduate School ___Graduate School

Occupation____

Do you plan to stay in your present field? ____ yes ____no

Financial:
Current source of income____________________________________.

Have you or do you currently have financial problems ? ___yes ___no
Please describe____.

Legal:
Anything pending legally?____

Past legal issues that caused stress____.

Spirituality:
What is your religious/spiritual affiliation? _______________________________________

Is your religious/spiritual community a resource for you? ____yes ___no

Leisure Activities:
Hobbies or leisure activities
____.

Military History:

Years of service____________________________.

Branch of service_____________________________.

Currently receiving services through military?___________________________________

Client Name | Therapist Signature | Date

Santa Fe Sage Counseling Center

Alcohol and Other Drugs ________________________
(name)

Chemical	Ever Used?	Used in past year?	Age at first use
Alcohol (beer, wine hard liquor)			
Marijuana, hashish			
Cocaine, crack			
Hallucinogens (LSD, acid, other)			
Speed, uppers, Methamphetamines			
Barbituates (downers, sleep pills)			
Tranquilizers, (valium, librium)			
Narcotics, (heroin, other opiates)			
Steroids			
Inhalants (glue, paint, aerosols, etc.)			
Nicotine			
Caffeine			

What negative consequences have you experienced from your use?___________________
____

Is anyone in your household currently misusing alcohol or drugs?_________________

_________________________________ ___________________________________

Client Name Therapist Signature Date

Santa Fe Sage Counseling Center

Medical History ______________________________
(name)

Name and address of your physician(s):____

____

____

List any significant **medical diagnoses** and conditions you have:____

____

____

List any **operations** and invasive procedures you have had:____

____

____

____

List any **physical concerns** you are presently having: (e.g.) high blood pressure, headaches, dizziness, etc.: ____

____

Are you being treated for any condition that requires **pain** management?____________________

____

Do you have any **allergies**? Yes ____ No ____
Please list your allerg(ies) and describe your allergic reaction (Use back if need more room.)

____

____

When was your last complete **physical exam**?______________________________________
Results of physical exam: ____
What prescription medications are you taking presently, and for what purpose? (Use back if need more space.)

____

____

____

____

____

Use of over-the-counter and herbal remedies ?

____

____

____

______________________________ ______________________________
Client Name Therapist Signature Date

Santa Fe Sage Counseling Center

Couples Relationship Concerns for ____________________________
(name)

What is your current level of marital happiness? (Circle one)

Extremely Unhappy	*Fairly Unhappy*	*A Little Unhappy*	*Happy*	*Very Happy*	*Extremely Happy*	*Perfect*

What is the major problem in your relationship? ____
____
____

How long have you had this problem? ____
____
____

When else have you had similar problems? ____
____
____

What would you like to see happen as a result of therapy? ____________________________
____
____

What is one thing you could personally do to improve the relationship regardless of what your partner does?____
____
____

Have you threatened separation or divorce as a result of the current problems? Yes/No

Do you perceive that either you or your partner has withdrawn from the relationship? Yes/No

How enjoyable is your sexual relationship? (Circle one)

Terrible	*More unpleasant than pleasant*	*Not pleasant, not unpleasant*	*More pleasant than unpleasant*	*Great*

How satisfied are you with the frequency of your sexual relations? (Circle one)

Way too often to suit me	*A bit too often to suit me*	*About right*	*A bit too seldom to suit me*	*Way too seldom to suit me*

To what degree do you have family or friends that support you as a couple? (Circle one)

Extremely high	*Very high*	*High*	*Moderate*	*Low*	*Very low*	*Extremely low*

To what degree do the two of you share a similar basic worldview? (Circle one)

Extremely high	*Very high*	*High*	*Moderate*	*Low*	*Very low*	*Extremely low*

______________________________ ______________________________
Client Name Therapist Signature Date