Intake Information

Date ____________

Name _______________________________ Age ___ DOB:_______

Spouse/Partner Name ___________________ Age ___ DOB:_______

Home Adress____
Street City/State Zip Code

Telephone (home)_______________ (work)______________ (cell)_____________

Current Employment:
Full-time Part-time Homemaker Unemployed Student Retired Disability

Employer_________________________ Occupation________________________

Your Annual Income_____________ Combined (self & partner) Income___________

Education Completed_________________________

Referred by________________________________ Phone __________________

Relationship to referral____

May I contact referral to acknowledge that you have begun therapy? _____yes ____no

In case of emergency notify:____
Name Relationship

___________________ ____
Phone Number(s) Address

Marital/Relationship Status: (circle all that apply)
Single (never married) Significant Other Cohabitating/Committed
Separated Divorced Widowed Remarried (after divorce)
Remarried (after spouse's death)

How long have you been married or in your current relationship?

Have you and your partner ever separated?
If yes, how long?

Have you ever consulted a lawyer regarding separation or divorce? When?

Children (include biological, adopted, foster, step, etc.):

Name	Sex	Age	Type (bio,step,etc.)

Do you ever wish you had NOT gotten into a relationship with your current partner?
Frequently Occasionally Rarely Never

If you had your life to live over, do you think you would:
Select the same partner Select a different partner Never get involved with anyone

Do you confide in your mate?
Almost never Rarely In most things In everything

Would you say you are satisfied with your sexual activities with your partner? Yes No
If not, in what way are you dissatisfied?

Have you ever been in therapy before? Yes No
If yes, briefly describe the reason(s), date(s), and length of treatment:

Was it a positive experience? Yes No
What did you like or dislike about it?

Are you currently having suicidal thoughts? Yes No
Have you ever seriously contemplated suicide? Yes No
Have you ever attempted suicide? Yes No
If yes, please describe:

Do you have any chronic illnesses, medical conditions, or injuries? Yes No
If yes, please describe:

Are you presently taking any medication (including prescription, contraception, herbal, and over the counter medications)? Yes No
If yes, please list:

What do you enjoy doing in your spare time?

Are there things that you used to do, or would like to do, but currently don't?

How would you describe your spiritual or religious beliefs?

Briefly describe your reason(s) for seeking therapy at this time:

What do you wish to accomplish through the process of therapy?

Is there anything else you think would be important for me to know about you or your family?

Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked

❑ I have no problem or concern bringing me here
❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Compulsions
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems

- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns ...")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues:

Please look back over the concerns you have checked off and choose the concerns that you most want help with.

Financial Agreement and Consent to Render Services

Today's Date: ___________________

Person(s) responsible for payment: ____
Name

____
Name

- I understand that I am responsible for payment of fees for services on each visit.
- I understand that services provided may not be covered through Health Insurance. I understand that it is the client's responsibility to determine if health insurance covers the services provided and will provide reimbursement.
- I authorize the therapist to release any medical information necessary to process an insurance claim.
- Missed appointments (unless cancelled 24 hours in advance) will be billed.
- Upon request I will be provided a statement of all charges.
- I do hereby seek and consent to take part in treatment by Pathways Behavioral Health, PLLC. I agree to take an active role in this process. I understand that no promises have been made to me as to the results of treatment.
- I am aware that I may stop treatment with Pathways Behavioral Health, PLLC at any time. I will still be responsible for paying for the services I have already received.

Fee per session: __________________

Date: __________________________

Signature of patient: ____ Date: __________
(Signature of parent or legal guardian if Client is under 18 years of age.)

Consent to Treatment

I do hereby seek and consent to take part in the treatment by Monica Hurt, LMFT. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this Monica Hurt, LMFT.

I am aware that I may stop my treatment with Monica hurt, LMFT at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment.

If I do not cancel and do not show up, I will be charged for that appointment.

I give permission for voicemails to be left at the following number:

I give permission for emails to be left at the following email:

I give permission for phone messages to be left with the following person:

I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

______________________________ ______________________
Signature of patient/client Date

______________________________ ______________________
Printed name Relationship to patient/client

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.

9/20/20