**Amanda Conner Counseling, LLC**

***Adult Intake Form***

(Please Print)

Date: \_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Middle) (Last) (Maiden)

Name you prefer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Circle) Sex: Male Female Race: White Black Hispanic Asian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suite/Apartment Number: \_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ May I send mail here: \_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suite/Apartment Number: \_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ May I send mail here: \_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message here: \_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message here: \_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message here: \_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I send email here: \_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT INFORMATION**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of employment: \_\_\_\_\_\_\_\_\_\_ Average hours worked per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average annual salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION INFORMATION**

(Circle) Last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in school? \_\_\_\_\_\_\_\_\_\_\_\_ If Yes, What school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONAL INFORMATION**

Current Status: 🞏 Single 🞏 Dating Are you content with your current status? \_\_\_\_\_\_\_\_\_

🞏 Engaged 🞏 Married If No, Briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Separated 🞏 Divorced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Widowed 🞏 Living Together \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Married, How long: \_\_\_\_\_\_\_\_\_\_ Number of previous marriages for you: \_\_\_\_\_\_\_\_\_ For your partner: \_\_\_\_\_\_\_\_

If Separated or Divorced, How long: \_\_\_\_\_\_\_\_\_\_ If Widowed, How long: \_\_\_\_\_\_\_\_\_\_

Partner’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Middle) (Last) (Maiden)

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ How long have you known your partner: \_\_\_\_\_\_\_\_\_\_\_\_\_

(Circle) Partner’s Sex: Male Female Partner’s Race: White Black Hispanic Asian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: (circle) Yes No Unsure Partner doesn’t know

With whom do you currently live *(Circle all that apply)*: Alone Boyfriend Girlfriend

Spouse Children Parent(s)

Sibling(s) Roommate Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDREN**

List your children (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: \_\_\_\_\_\_\_\_\_ If Yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a miscarriage: \_\_\_\_\_\_\_\_\_ If Yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an abortion: \_\_\_\_\_\_\_\_\_ If Yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY OF ORIGIN**

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, Sibling, Step) | Occupation | Describe Him/Her |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY PHYSICIAN INFORMATION**

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently receiving medical treatment: \_\_\_\_\_\_\_ If Yes, Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments you have had (Use back if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

List all current medications you are taking, including those you seldom use or take only as needed (Use back if necessary):

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking these medication(s) according to your doctor’s recommendations: \_\_\_\_\_ 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 | Dizziness------------------ 🞏 Past 🞏 Present | Stomach Trouble-------- 🞏 Past 🞏 Present |
| Visual Troubles---------- 🞏 Past 🞏 Present | Sleep Trouble------------ 🞏 Past 🞏 Present | Trouble Relaxing-------- 🞏 Past 🞏 Present |
| Weakness----------------- 🞏 Past 🞏 Present | Tension-------------------- 🞏 Past 🞏 Present | Rapid Heart Rate-------- 🞏 Past 🞏 Present |
| Difficulty Breathing----- 🞏 Past 🞏 Present | Intestinal Trouble------- 🞏 Past 🞏 Present | Hearing Noises---------- 🞏 Past 🞏 Present |
| Change in Appetite----- 🞏 Past 🞏 Present | Tiredness----------------- 🞏 Past 🞏 Present | Pain------------------------ 🞏 Past 🞏 Present |
| Hearing Voices---------- 🞏 Past 🞏 Present | Seeing Things------------ 🞏 Past 🞏 Present | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Past 🞏 Present |

Your Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Your Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has Your Weight Changed in the Last 2-3 Months: \_\_\_\_\_\_\_\_

**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 | Terminal Illness----------🞏 Past 🞏 Present | Recent Death-------------🞏 Past 🞏 Present |
| Grief------------------------🞏 Past 🞏 Present | Hopelessness-------------🞏 Past 🞏 Present | Loneliness-----------------🞏 Past 🞏 Present |
| Shyness--------------------🞏 Past 🞏 Present | Fears------------------------🞏 Past 🞏 Present | Friends---------------------🞏 Past 🞏 Present |
| Marriage-------------------🞏 Past 🞏 Present | Communication----------🞏 Past 🞏 Present | Physical Abuse-----------🞏 Past 🞏 Present |
| Emotional Abuse--------🞏 Past 🞏 Present | Verbal Abuse-------------🞏 Past 🞏 Present | Sexual 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 | Pornography--------------🞏 Past 🞏 Present |
| Self-Harm------------------🞏 Past 🞏 Present | High Risk Behavior------🞏 Past 🞏 Present | Zoning/Blanking Out----🞏 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had them in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide: \_\_\_\_\_\_\_\_ If Yes, when and how: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of your friends or family ever committed suicide: \_\_\_\_\_\_\_\_ If Yes, when and who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING ISSUES AND GOALS**

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 to 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELIGIOUS BACKGROUND**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Church attendance? If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like spiritual/religious principles incorporated into your therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TERMS OF SERVICE**

I hereby give Amanda Conner Counseling, LLC permission to provide therapy services for the patient mentioned above:

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

**Amanda Conner Counseling, LLC**

***Financial Policy***

**Payment Policy: •** Payment for services is due at the time of service.

• Private pay one 50-60 minute session fee: $100

* Open Path Psychotherapy Collective and/or EAP clients are subject to differing fees from listed above.

• Additional Services: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference Calls, if

requested, will be billed in 15 minute increments @ $15 per 15 minutes of billable services.

• Administrative Services: Letters, insurance forms, authorization requests will be billed @ $20 each request.

• Court Appearances and Depositions are billed at $500 per half day (3 hours) with $300 minimum.

• Returned checks are subject to a $35 fee.

• No-show fees are charged for appointments cancelled or broken without 24 hours advance notice, unless there is an

emergency or illness. Monday appointments must be cancelled by the Friday in advance at Monday appointment

time or before. The no-show fee is $100, unless otherwise specified by Amanda Conner Counseling, LLC.

* When leaving a message, all calls are time and date stamped.

• Payment by credit cards: $2 per transaction.

• All clients must keep an updated credit card authorization on file with Amanda Conner Counseling, LLC.

**Policy on Insurance Reimbursement:**

If you have medical insurance that provides coverage for mental health counseling, we are happy to help you receive your maximum allowable benefits. We can provide you with a receipt (“superbill”) to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, called “Usual, Customary and Reasonable” (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is recommended that you check your mental health benefits and your deductible before generating a claim.
4. Please be aware that we are required to give you a mental health diagnosis which will remain in your permanent records if you file with your insurance.
5. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this policy.

**Rate Policy:**

• Appointments are scheduled directly with the therapist.

• Fees listed are for one clinical hour (50-60 minutes). Longer sessions are calculated by .5 hour increments ($50 per half hour).

• Proof of income may be required if your fee is reduced. All financial information is kept confidential.

We understand 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.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

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Section applicable only for reduced fees:

Clients Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Amount agreed upon for therapy per 50-60 minute session $ \_\_\_\_\_\_\_

• Time agreed upon for reduced fee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Date fee agreement revisited \_\_\_\_\_\_\_\_\_\_\_\_ Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Amanda Conner Counseling, LLC**

***Informed Consent & Release of Liability***

This form is to document that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission and consent for treatment to **Amanda Conner, MMFT, LMFT of Amanda Conner Counseling, LLC**, to provide therapy for me.

I understand the following: (please initial beside each statement)

\_\_\_\_\_\_\_ This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during

weekend and evening hours.

\_\_\_\_\_\_\_ Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications, if such a situation arises the therapist will make reasonable efforts to resolve these situations before breaking confidentiality.

\_\_\_\_\_\_\_ I am financially responsible for this treatment.

\_\_\_\_\_\_\_ I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

\_\_\_\_\_\_\_ I have read and received a copy of the HIPPA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.

\_\_\_\_\_\_\_ I understand that my case may be reviewed by state approved supervisors with my confidentiality to be held in highest regards.

\_\_\_\_\_\_\_ I understand that peer-to-peer supervision may be done on a case-by-case basis.

***Disclosure Statement***

Your decision to enter into therapy was undoubtedly a serious one arrived at after considerable thought. Whether you were referred by your physician, urged to come by family or friends, or have come because of problems and feelings only you know about, the decision to come here was yours.

Therapy is a two-way effort entailing mutual respect, responsibility and consideration between you and your therapist. The policy presented is designed to make your therapy productive and to avoid any misunderstanding regarding the mutuality of the therapeutic process.

As a Marriage and Family Therapist, my area of training is the systemic treatment of individuals, couples, and families. The systemic approach to therapy takes into consideration all immediate family members in family therapy sessions. I, along with you, will decide which family members (if any) need to be included in therapy. Various goals will be established together with you at the beginning of therapy.

Therapy naturally involves activities such as identifying emotions and revealing secrets. There may be risks associated with our disclosures to other family members or other family members’ disclosures during the course of therapy, as well as exploration of issues. Decisions to disclose will be made by you except where mandated by law. It is expected that some uneasiness or painful emotions may occur as you are involved in therapy. Discussing painful issues will naturally create discomfort. Your participation in therapy is essential toward helping address your concerns. The Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialists requires that all clients be informed that all forms of dual relationships such as business ventures and sexual intimacy are prohibited.

Please be aware that there is a higher incidence of divorce if only one partner in a relationship is involved in therapy. It is also important that you understand there is no guarantee all of your concerns, issues, feelings, or problems will be successfully resolved. I cannot guarantee outcomes. The outcomes may vary from your expectations. You may discontinue participation in therapy at any time. If you are not satisfied with the course of the therapy, please discuss these concerns with me.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

**Amanda Conner Counseling, LLC**

***Acknowledgement of Receipt of Notice of Privacy Practices***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of Amanda Conner Counseling, LLC Notice of Privacy Practices. (Print Full Name)

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

***Acknowledgement of Receipt of Emergency Information***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of Amanda Conner Counseling, LLC Emergency Information.

(Print Full Name)

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

***CLIENT E-MAIL USAGE CONSENT***

Your therapist will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks identified below, your therapist cannot guarantee the security of email communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist’s intentional misuse.

**RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR THERAPIST**

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

• E-mail can be circulated, forwarded and stored in numerous paper and electronic files.

• E-mail can be received by unintended recipients.

• E-mail senders can easily type in the wrong email address.

• E-mail is easier to falsify than handwritten or signed documents.

• Backup copies or e-mail may exist even after the sender/recipient has deleted their copy.

• Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.

• E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

• E-Mail can be used to introduce viruses into computer systems.

• E-mail can be used as evidence in court.

**CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL**

• Use e-mail for general client information only.

• Follow-up with your therapist if you have not received a response to your email within 5 business days.

• Take precautions to preserve the confidentiality of e-mail. Use screen savers and safeguard your computer with a password. Change your password regularly.

• Inform your therapist of any changes to your e-mail address.

• Withdraw consent to email client information through hardcopy written communication to your therapist.

**ALTERNATE FORMS OF COMMUNICATION**

I understand that I may also communicate with the therapist via telephone or during a scheduled appointment and that the e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

**TYPES OF E-MAIL TRANSMISSIONS THAT CLIENT AGREES TO SEND AND/OR RECEIVE**

The types of information that can be communicated via e-mail with your therapist includes: appointment scheduling requests, billing and insurance questions and client education. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should schedule an appointment.

**HOLD HARMLESS**

I agree to indemnify and hold harmless Amanda Conner, Amanda Conner Counseling, LLC, and any employees, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney’s fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the therapist or the use of the therapist’s web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The therapist does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the therapist’s website or server that makes such site available is free of viruses or other harmful components.

I also understand that all of the above information, notice and agreements apply for text messages sent to or from the therapist’s personal office cell phone.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

**Amanda Conner Counseling, LLC**

***Notice of Privacy Practices***  KEEP FOR YOUR RECORDS

**This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.**

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc. Health care providers may include physicians, school counselors, social workers, etc.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

• Health Care Operations include-the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment' options or other health- related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

• You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to Amanda Conner Counseling, LLC •

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

• The right to request an amendment to your PROTECTED HEALTH INFORMATION.

• The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact: South Carolina Labor, Licensing, and Regulation

[www.llr.state.sc.us/pol/counselors/index.asp?file=CCE.htm](http://www.llr.state.sc.us/pol/counselors/index.asp?file=CCE.htm)

For more information about HIPPA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, S.W.

Washington D.C. 20201

887-696-6775 (toll-free)

**Amanda Conner Counseling, LLC**

***Emergency Information*** KEEP FOR YOUR RECORDS

If you need to contact me, please leave a message on my personal office cell phone (828-919-1158). I strive to return all calls in a timely manner. As I do not have a receptionist, I will be checking voicemail throughout the day. My goal is to return your call within a 48-hour period with the exception of weekends and holidays. If you have an emergency, please call 911 or go to the nearest emergency room.

The following are some emergency numbers for your reference:

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

Spartanburg Regional Emergency Room: (864) 560-6222

Spartanburg Mental Health Crisis Line: (864) 585-0366

24-hour Child Abuse Line: (864) 585-1445