MINOR: 14-17

Intake Questionnaire

Please fill out this form to help your therapist know more about you so your counseling sessions can focus on what's most important to you.

Minor **Today's Date**____________________

Name of Client____Age_____DOB______/_____/__________

Place of Birth: _________________________________ Gender: F / M

Address____City & Zip_________________________

Phone: ____

OK to leave **Voice and Text** messages at this phone? Yes/No

School Currently Attending____Grade___________________

IEP?______________ 504 Plan?_________

Parental Custody / visitation____

Occupation_____________________________________Employer_______________________________________

Family

Names of all persons living in same home(s) with child

Name	Age	Gender	Home (if different)	Relationship

Reasons for seeking counseling at this time____

____

____

What have you tried to do up to now to resolve these issues?____

____

What do you hope to accomplish in counseling?____

____

____

Have you seen a counselor before today? ___Yes ___No Dates_______________________________________

How did it help?____

____

What medications do you take?____

____

Describe any significant medical history:____

____

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What else is related to this problem?

__Stress	__Hearing voices
__Chronic pain	__Racing thoughts
__Loneliness	__Physical abuse
__Indecisiveness	__Loss of control
__Fatigue	__Drug use
__Controlled by others	__Impulsive behavior
__Relational issues	__Sexual problems
__Feeling worthless	__Depression
__Compulsive behavior	__Gender identity
__Obsessive behavior / thoughts	__Loss of appetite
__Seeing things that others don't	__Trouble sleeping
__Grief	__Unwanted memories
__Sexual abuse	__Pregnancy / Abortion
__Sexual addiction	__Career choices
__Poor concentration	__Anxiety
__Low self-esteem	__Fears
__Aggression	__Panic
__Eating problems	__Anger
__Emotional abuse	__Bad dreams
__Spiritual / Faith concerns	__Apathy
__Forgiveness Issues	__Alcohol use
__Verbal abuse	__ Work issues
__Controlling	__ Loss
__Shyness	__Other________________________________

Are you currently experiencing any suicidal thoughts? Yes / No

Have you experienced suicidal thoughts or attempted suicide in the past? Yes / No

Are you currently experiencing any violent or homicidal thoughts? Yes / No

Do you need to be here (Your Opinion)? Yes / No

Do you want to be here? Yes / No

Please feel free to include any other information you think is important here:

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Wendy Reimann, LMFT, LPC
Journeys of Life Counseling, LLC
Consent for Counseling Services
General Information Agreement for Therapy Services

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis. Further information is detailed in HIPAA Notice of Privacy Practices posted online at journeysoflifecounseling.com.

Please print your name on the top line, and sign at the X.

I, (name of client)____ request professional counseling, talk therapy services.

I agree that I will schedule and verify my appointment times with my therapist, and I will show up on time for my appointments.

If for some reason I cannot show up for my appointment as scheduled, 24 hours before the scheduled time I will contact my therapist by phone.

I understand that my therapist **will not** be available for 24 hour crisis intervention or emergencies and I have been informed who to contact if I have an emergency; 911 or local Crisis Line 503-291-9111.

I acknowledge that I have received a Professional Disclosure Statement from my therapist and the HIPAA Notice of Privacy Practices is posted at JourneysOfLifeCounseling.com. I will review the documents and know that I am encouraged to discuss any further questions with my therapist at any point in my treatment.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above and the understanding that my therapist will clarify goals and objectives at any time.

X____ _______________
Client Signature Date

Fee Agreement: I_________________________ agree to the fee schedule as outlined by Wendy Reimann of Journeys of Life Counseling, LLC ($120/session) unless otherwise noted here.
Fee Agreement:____

X____ _______________
Signature of Party Responsible for Fee Date

I, _______________ Therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. Signature of Therapist_________________________ Date_____________

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