Journeys of Life Counseling

INDIVIDUAL

Confidential 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.

Name_____ Date_____
Spouse_____
Phone #: Cell: _____Other:_____
Ok to leave voice and text messages at these phone numbers? Yes / No
Email:_____
Address:_____
Date of Birth:_____ Place of Birth: _____Age:_____Gender: F / M
Your education: Highest Grade / Degree / Certificate: _____
Occupation (former, if not working): _____
Person and phone number of whom to call in emergency and relationship to you (Spouse, Parent, Child, Friend, etc.)

_____
Referral source or how you came here:_____
Past/Present Medical Issues (Brief summary of major medical problems, surgeries, accidents, falls, illness, etc.):

_____
_____
Medication you are presently taking and for what. (Brief summary):

_____
_____
Past/present drug/alcohol use/abuse, treatments (Brief summary):

_____
Any suicide attempt(s) or violent behavior (describe: ages, reasons, circumstances, how, etc.)

_____
Have you or any of your family had concerns with depression, anxiety, suicide attempts, mental illness?
No Yes If "Yes," please explain briefly.

_____
Are you involved in any current pending civil or criminal litigation(s), lawsuit(s) or divorce or custody dispute(s)?
No Yes If "Yes," please explain briefly.

_____
Your current marital status: Never Married / Married / Partnered / Separated / Widowed/ Divorced
Past and present significant relationships:_____

_____
What other family do you have?_____
Among your friends and family, whom do you count on for support?

_____
Have you ever been diagnosed with a mental disorder? No Yes If "Yes," please explain

_____
Have you experienced counseling before? No / Yes Was it helpful? No / Somewhat / Yes
With whom?_____When_____
Reasons for prior therapy_____# of sessions_____

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How would you rate your daily:

Peace vs. worry level?	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Calmness vs. tension level?	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Current physical health?	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Eating habits?	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Exercise habits?	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Sleeping habits?	Very Good	Good	Satisfactory	Unsatisfactory	Poor

List any specific sleeping concerns_____
Please describe yourself spiritually

_____

What gives you the most joy or pleasure in your life?

_____

What are your main worries and fears?

_____

What are your most important hopes or dreams?

_____

As specific as possible, what are your expectations of counseling?

_____

Do you have any concerns about the counseling process?

_____

Please describe what you want to work on in therapy; what do you want to be different in your life?

_____

_____

How long has this been troubling you?_____yrs. How bad is it? Mild Moderate Serious Severe

_____

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_____

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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.

Name_____I 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_____ _____
Signature of Client 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 Client 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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