Great Life Counseling Center
14275 Midway Rd., Ste. 260
Addison, TX 75001
Jantel Jordan, Psy.D./413-798-4522/GREATLIFECONSULTS.COM

~ Welcome ~

Please read and complete the forms of this packet. Please note any questions you have and discuss them with your psychologist prior to or during the first session.

Packet Contents:

1. **Demographic/Financial Responsibility Form**
   (*each person must sign*)
2. **Private Fee Schedule Form**
   (*each person must sign*)
3. **Credit Card Authorization Form**
   (*please complete this form, even if you plan to pay by cash or check*)
4. **Office Policies and Consent to Treatment Form**
   (*each person must sign*)
5. **Supervision/Consultation Disclosure Form**
   (*each person must sign*)
6. **Notice of Audio/Video Recording Form**
   (*each person must sign*)
7. **Intake Questionnaires**
   (*each person needs to privately complete his/her own*)

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DEMOGRAPHIC/FINANCIAL RESPONSBILITY FORM

Name/Partner A: ________________________________ DOB: ______/______/______ Age: ____________

Home Phone: ____________________ Cell: _____________________ E-mail:_________________________

I authorize text messages to my cell phone and messages to the contact numbers & email provided YES NO

Residential Address: ________________________________ City: ________________ Zip: ___________

Employer: __________________________________ Position/Type of Work: _______________________

Name/Partner B: ________________________________ DOB: ______/______/______ Age: ____________

Home Phone: ____________________ Cell: _____________________ E-mail:________________________

I authorize text messages to my cell phone and messages to the contact numbers & email provided YES NO

Residential Address: ________________________________ City: ________________ Zip: ___________

Employer: __________________________________ Position/Type of Work: _______________________

Referred by: ☐ Insurance Company ☐ Internet Search ☐ Physician ☐ Friend ☐ Other: ______________________

Insurance information

Name of Insured (Policy holder):___________________________ Date of Birth of Insured: _____/_____/_____

Insurance Carrier: __________________ Insurance Phone#: ___________________ Co-pay $________________

Deductible: ________________ Deductible Met: ________________ Pays at: ____________________________

Policy/ ID#: ___________________ Group#: _________________ Employer: _____________________________

FINANCIAL RESPONSIBILITY

- ➢ Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO.
- ➢ If you would like to pay through BCBS, please contact your representative to verify your behavioral healthcare coverage & inform your psychologist prior to your initial appointment.
- ➢ Great Life Counseling Center will electronically submit claims to BCBS. BCBS will be billed for the contracted service fee minus your copayment or your full payment of the contracted service fee will be credited toward your deductible. Great Life Counseling Center may be required to release treatment information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
- ➢ Private payment of services, copays, and administration fees are due at the time of each appointment. Walkout statements for out of network claims can be downloaded through your profile with our electronic health records system-TherapyAppointment.com.
- ❖ If your insurance company should deny payment or reimbursement, you remain ultimately responsible for any outstanding financial debt associated with services provided, including no show/late cancellation fees (which are not covered by insurance). Great Life Counseling Center reserves the right to charge your credit card on file or other credit cards used for prior payments, email or mail client an invoice, and/or utilize a collection agency in efforts to address outstanding balances. You are also responsible for making sure Great Life Counseling Center has updated contact & billing information.

Please Acknowledge the Above Statements with Initials _________ _________

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FEES & PAYMENT:

- Payment is due at the time services are rendered in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center.** MasterCard, Visa, American Express, & Discover are accepted. Detailed receipts can be downloaded from your profile on TherapyAppointment.com.
- Clients will be given the option to add no show or late cancellation charges to the cost of the next session, as long as the next session is scheduled to occur within 10 days of the cancellation. Clients are also welcome to mail a check by the 10 day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.

SUMMARY OF PRIVATE PAY FEES

Direct Contact Fees (may be covered by insurance):

Couples Psychotherapy Sessions (55-60 min)……………………………………**$150/hour**
……………………………………**Additional time pro-rated by 15 minute increments**
……………………………………**Weekend session surcharge (per 55 minutes) = $20/hour**

Phone & E-Consultation fees (not covered by insurance)………………………**15 min. or less = FREE;**
………………**15+ min. = Clinician's hourly rate (pro-rated)**

Phone & E-Consultation fees ………………………**15 min. or less - FREE; 15+ min. - Clinician's hourly rate (pro-rated)**

Indirect contact/Administration fees (not covered by insurance)

Other services (i.e. write letters, fill out forms, report writing)…………………………**Clinician's hourly rate (pro-rated)**
Legal (i.e., attorney calls, reports, testimony preparation & court appearances)…………………**$300/hour (pro-rated)**
……………………………………………**(4 hour minimum/retainer = $1200)**
Preparation of Record Summary Letters.…………………………………**Clinician hourly rate (pro-rated)**
Returned/Invalid Check Fee……………………………………………**$50.00**
Late Cancellation Fees (less than 24 hours of notice)……………………………**50% of clinician's hourly rate**
No show Fees (notice not provided prior to scheduled appointment time)……………**100% of clinician's hourly rate**

- If your Great Life clinician has authorized a session rate modification/discount/coupon, please note on line below.

____

- Clients are responsible for making sure Great Life Counseling Center has updated contact & billing information. Clients are financially responsible for costs incurred when an insurance claim is denied due to changes in, lapses or exhaustion of benefits or termination of coverage for any reason. Great Life Counseling Center reserves the right to charge a client's credit card, email or mail client an invoice, and/or utilize a collection agency in efforts to address outstanding balances.

With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered. I authorize Great Life Counseling Center to bill me directly for services provided, not covered by insurance, or any administration fees not covered by insurance.

Client/Partner Signature: ___________________________________ **Date:** ____________

Client/Partner Signature: ___________________________________ **Date:** ____________

A copy of this completed & signed document will be provided at your request.

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Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****
This policy exists both for your convenience as well as a way to insure that outstanding balances are paid in a timely manner. You will be notified via phone/voicemail, text, and/or email prior to any charges being applied to your card.

With my signature, I authorize Great Life Counseling Center to charge my credit/debit card & imitate my signature for the e-sign authorization for the following outstanding charges:

- **All visits for which payment was not made at time of visit (this includes fees for service, deductibles, and co-pays).**
- **50% of the session fee for each late cancellation (less than 24 hours of notice)**
- **100% of the session fee for each no show**

_______________________________________ _______________________
Client/Card Holder Signature **Date**

Name ____
Print Last *First* *Middle Initial*

Name on Card (if different)

Type of Card: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Credit Card Number _______ - _______ - _______ - _______ CVV Number ________ 3-digit number on **back of** card or 4-digit number on **front** of AE card

Expiration Date __ / ____

Card Holder's Billing Address for Credit Card Statements:

____
Street Address Apt./Ste./Room #

____
City *State* *Zip*

Card Holder Signature ___________________________________, Date ____ /_____ /____

Email address and/or phone number for receipts________________________________

A copy of this completed & signed document will be provided at your request.

Office Policies and Informed Consent

Office Policies and Informed Consent

Welcome and thank you for entrusting Great Life Counseling Center with your care! This document contains important information about our professional services, business practices, and it will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss.

THE THERAPY PROCESS

Psychotherapy is treatment process in which the results tend to be gradual and long lasting. Research shows client satisfaction with treatment is highly correlated with the quality of the therapeutic relationship. Great Life Counseling Center aims to provide a comfortable & inviting environment where clients can share their strengths and celebrations as well as work through their challenges sorrows. Psychotherapy treatment will foster collaboration, candor, and accountability as every discussion shares the aim of fostering the healthy development of each client's relationship with their self, family & community. Tools & information gained from the psychologist's years of formal education & professional experience will be shared whenever relevant & appropriate. However, some of the most powerful breakthroughs or revelations often come from the psychologist's facilitation of the client's self-discovery. This self-discovery includes, but is not limited to, increased awareness & development of personal strengths & resilience due to a healthier perspective, sense of direction, and greater resolve.

Although therapy has many potential benefits, there are some inherent risks or challenges. Therapy often requires clients to be vulnerable with their psychologist as they recall unpleasant events and discuss troubling or embarrassing issues. Consequently, people sometimes experience some feelings of discomfort or distress in reaction to issues discussed during sessions. However, therapy has been shown to have benefits for those who undertake it with a competent & genuine clinician. Although there are no guarantees about the outcomes of therapy, individuals often report significant reductions in feelings of distress, a greater sense of resolution or peace about losses experienced, improved relationships and self-esteem, more effective coping and resource utilization, and a greater outlook on life.

Similar to any other relationship, therapy is most effective when the interpersonal chemistry, collaboration and candor between the client and psychologist are healthy and evident during each interaction. It is important clients understand that achieving the benefits of therapy requires much effort on their part, including consistent attendance & active involvement, honesty (with client's self & psychologist or therapist), and follow-through (on recommendations & agreements). The psychologist's role is to listen, assess, and intervene with questions/suggestions/recommendations that will strengthen your personal reflections, problem solving skills, coping skills, and overall perception of life's challenges. Clients are encouraged to make efforts to be self-reflective, forthright & honest with psychologist, and open to considering new perspectives & behaviors.

"No-secrets" policy:

Sometimes individual consultations or sessions may be necessary to discuss individual issues that are affecting the couples/family therapy process or there may be an issue that one partner is struggling to disclose with the other. However, it is important psychologists/therapists remain objective and trustworthy to all participants. Therefore, clients are encouraged to not share information with psychologist/therapist that they are not willing to share with their partner. In the event that therapist agrees to meet with either partner alone, the client/partner will likely be challenged to disclose such "secrets" in the next session with the psychologist's help or support. The psychologist will help the client/partner prepare to share the information more effectively as well as cope with the consequential feelings & reactions that may occur for either partner following a challenging disclosure.

Termination of Therapy Process

Ideally, sessions & consultations will end when psychologist & clients agree treatment goals have been adequately met. However, there are times when therapy sessions need to be discontinued for a time or spaced out due to financial reasons, conflicts in schedule, or physical illness. The psychologist may also decide one or both clients would be better served by another clinician and provide referrals for the transfer of care to qualified colleague.

Regardless of reasons for termination, continuity of care is vital to effective treatment and clarity of the therapeutic relationship status is necessary for accurate record keeping. Thus, clients are strongly encouraged to inform their therapist of their intention to terminate sessions at least one session in advance so proper closure can be achieved. In the event sessions have been discontinued without notice, the termination of the therapy relationship will be assumed after 2 weeks of no sessions being scheduled. At such time, clients will be sent an email informing them of this default termination.

Former clients are welcome to reenter treatment but they are not guaranteed the same time slot or rates. Former and current clients are encouraged to complete customer satisfaction surveys to provide Great Life Counseling Center with feedback on how to serve its clients better.

OUTSIDE-OF-SESSION COMMUNICATION & EMERGENCY PROCEDURES/POLICIES:

- Telephone, text, & email consultations between office visits are welcome. However, any contact outside of session will be kept brief. Clients are encouraged to consider scheduling additional sessions or waiting until their next session to discuss matters that will take more than 15 minutes to explore. If out-of-session correspondence requires more than 15 minutes of the psychologist's time, charges for each 15-minute increment will incur (including the first 15 minutes). Payment for such consultations is due at the start of the next session or within 10 business days (whichever occurs first).

- **Clients are welcome to transmit voicemail, email, or text messages to their psychologist/clinician but these communications must remain brief (i.e., not requiring more than 15 minutes of therapist's time to review & respond) or charges will incur**. On weekends and holidays, messages are checked less frequently. Calls, texts, & emails will generally be responded to within 24 hours or by the end of the next business day.

- **Please note: Great Life Counseling Center's contact numbers are *not* emergency numbers. In the event of a mental health or medical crisis, please call 911 or one of the following crisis lines, which are available 24/7:**
  - Suicide & Crisis Center of North Dallas – **214-828-1000**
  - National Suicide Prevention Lifeline – **1-800-273-TALK**
  - National Domestic Violence Hotline – **1-800-799-SAFE**
  - National Sexual Assault Hotline – **1-800-656-HOPE**
  - If your crisis is due to a medical issue or medication, contact your physician or psychiatrist.

- Vacation: Clients are informed in advance whenever their psychologist plans to be unavailable for more than 48 hours. In these events, arrangements may be made for coverage, if the psychologist determines its necessary or it is requested by client. Otherwise, clients who experience pressing concerns while their therapist is unavailable are encouraged to utilize one of the crisis lines listed above.

CONFIDENTIALITY

In most cases (see "Exceptions to Confidentiality" below) communications between client and psychologist will be held in strict confidence - unless client provides psychologist with written permission to release

information about treatment. In the case of couples or family therapy, the psychologist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all adult participants or legal guardians provide written authorization to release such information.

Protecting client privacy is a high priority for Great Life Counseling Center clinicians. Intake paperwork, therapy notes, consultation notes, & reports are all electronically archived. Each item is password protected whenever possible and the files are eventually archived on an accredited web-based electronic health records system called Practice Fusion. Scheduling & file information on Practice Fusion is protected with bank-level security, which includes the highest levels of data infrastructure, virus prevention, spam filtering, and encryption measures. Prior to being archived, encrypted records are kept on a secured flash drive so they are not saved on any computer. For additional information about your privacy rights & HIPPA, visit the HIPPA website:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

EXCEPTIONS TO CONFIDENTIALITY

Safety Concerns

Psychologists & other mental health professionals are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Psychologists may also break client confidentiality in order to prevent clients from harming themselves or others. If your psychologist suspects or observes the therapy process is leading to violence or abuse, sessions may be paused or terminated until both partners can commit to exercising a reasonable amount of self-control.

Professional Consultation

In accordance with recommended best practices, Great Life Counseling Center clinicians regularly consult with each other and enjoy collaborating to provide the best care possible. These consultations may include the review of video recordings or just an exploration of different strategies for improving the likelihood of positive outcomes. However, identifying information is never shared with anyone outside of the clinical team and, after recordings or presentation materials have been reviewed by the Great Life Counseling Center team, they are immediately shredded or deleted.

Electronic Communication, Videoconferencing, or Phone

Great Life Counseling Center is nearly paperless business and relies on different information technologies such as emails, text messages, phone calls, video conferences, fax, & an electronic medical record system to communicate, record, and store client information as well as transmit business transactions. Use of these technologies allows Great Life Counseling Center to serve your needs more efficiently and effectively and Great Life Counseling Center associates take reasonable steps to protect the privacy of its clients & minimize risk of any breach or errors in transmission. However, clients are required to acknowledge and accept the inherent risks of such technologies and electronic mechanisms (e.g., risk of information being erased or destroyed due to a malfunction or act of God; information intercepted and/or hacked by unauthorized parties; or information being erroneously transmitted to the wrong email, fax number, or phone number).

Agreement to Participate in Good Faith:

In order for each client/partner to participate fully and safely in the therapeutic process, Great Life Counseling Center requires that each partner/client agree not to ever request or have a legal representative subpoena records for purposes of litigation against the other. To further protect the privacy of each client/partner, session records will be brief & general and considered joint property so it can not to be released without both clients/partners being made aware of the request and consenting. If an agreement cannot be reached about the release of the record, the client/partner requesting the record will accept a personal summary letter regarding their personal attendance.

Clients/partners anticipating legal proceedings (such as divorce and custody disputes) must wait until after legal proceedings are completed to begin treatment. If treatment has already begun and legal proceedings are imminent, clients/partners are asked to preserve the integrity of the sessions and avoid involving their Great Life Counseling Center clinician in legal proceedings. If your Great Life Counseling Center clinician is subpoenaed and required to participate in a legal proceeding, the client/partner whose representative issued the subpoena shall compensate therapist at the rates described in the 'Summary of Private Pay Fees' section of this packet.

CLIENT ACKNOWLEDGEMENT OF POLICIES AND CONSENT TO TREATMENT:

- With my signature below, I acknowledge that I have had ample opportunity to read the information in this policies & consent to treatment document.
- My signature also indicates that I understand & accept the stated policies, expectations for participation, fees, and risks noted herein.
- Finally, my signature indicates my willingness & commitment to abiding by the terms of this agreement, fully participating in the treatment process, and paying for all services rendered in a timely fashion.

Client/Partner signature ____________________________________**Date**_________________

Client/Partner signature ____________________________________**Date**_________________

A copy of this completed & signed document will be provided at your request.

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Supervisory/Consultation Disclosure Form

Jantel Jordan, Psy.D. is a Postdoctoral Fellow at Great Life Counseling Center. In order to become a Postdoctoral Fellow for Great Life Counseling Center, Dr. Jordan had to achieve her doctorate in the field of psychology along with at least 3 years of experience practicing at other clinical sites. Dr. Jordan is now eligible for provisional licensure in the state of Texas and she has begun the application process. She has been authorized by the Texas State Board of Examiners of Psychologists to practice as a trainee under the guidance of a Texas licensed psychologist in good standing.

In order to ensure the highest standard of care, Dr. Jordan and her primary supervisor will meet weekly to discuss and review Dr. Jordan's documented work with you. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision and case consultations with members of the Great Life Counseling Center clinical team. Great Life Counseling Center is able to assure the highest quality services to each client due to an emphasis on qualitative reviews, training, and clinical collaboration.

This form will become part of your clinical record and a hard copy will be provided to you upon request. If you have any questions about this form, you are welcome to consult Dr. Jordan or one of her supervisors for clarification. Signing this form acknowledges your informed consent for treatment by a clinician under supervision, including your permission for your clinician to disclose your confidential information with her supervisor and consult with other members of the Great Life Counseling Center clinical team. You will have the right to withdraw permissions for consultation disclosure at any time but it will result in the transfer of your clinical work to a licensed psychologist.

Therapist's Name: Jantel Jordan, Ph.D.
Primary Supervisor's Name: Nikki Stillo, Ph.D.
Secondary Supervisors' Names: Kevin Lambert, Psy.D. and Blair Kenney, Psy.D.

Client/Partner signature ____________________________________Date_________________

Client/Partner signature ____________________________________Date_________________

A copy of this completed & signed document will be provided at your request.

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Notice of Video Recording

Great Life Counseling Center is able to assure the highest quality services to each client due to an emphasis on qualitative reviews, training, and clinical collaboration. In order to ensure the highest standard of care and safety, Great Life Counseling Center audio/video records office activity for surveillance purposes and your Great Life Counseling Center clinician may audio/video record clinical meetings for research/training purposes. Recordings of clinical meetings may be qualitatively reviewed during supervision/consultation meetings and group case consultation meetings with members of the Great Life Counseling Center clinical team. The limits of confidentiality delineated in the Consent for Counseling Treatment form apply to supervision/consultation meetings and group consultations with members of the Great Life Counseling Center clinical team.

This form will become part of your clinical record and a hard copy will be provided to you upon request. If you have any questions about this form, you are welcome to consult your Great Life Counseling Center clinician for clarification. Your signature below indicates you give Great Life Counseling Center and your clinician permission to audio/video record and you understand the following:

1. **The purpose of audio/video recordings shall be for training/research and surveillance of office premises. Your Great Life clinician may utilize samples of or complete audio/video recordings for qualitative reviews and constructive feedback from members of the Great Life Counseling Center clinical team.**
2. **The content of these recordings will be kept in strict confidence through encryption and a secure storage system. Furthermore, they will be deleted after they have served their purpose or 4 weeks has passed since the recording. Recordings of clinical meetings will be stored separately from the clinical record and will not be transmitted to or shared with any external entities or persons prior to deletion.**
3. **The use of personal recording devices (e.g., phones) to record all or parts of clinical sessions without the expressed consent of the Great Life Counseling Center clinician is strictly prohibited.**
4. **You may request in writing the suspension or termination of audio/video recordings of clinical meetings at any time by requesting to sign the terminate/suspend session recordings form. Office surveillance of common areas like the waiting room and hallways can not be terminated or suspended for security reasons but will be kept confidential until deleted.**

Client/Partner signature ___________________________________Date_________________

Client/Partner signature ___________________________________Date_________________

A copy of this completed & signed document will be provided at your request.

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COUPLES THERAPY INTAKE QUESTIONNAIRE

(*EACH PARTNER NEEDS TO COMPLETE THIS FORM SEPARATELY)*

NAME: ____

What brought you into therapy at this time (i.e., what events or conversations prompted the action)?

____
____
____
____
____
____

What do you wish to change or accomplish as a result of therapy? (Describe 3 improvements you hope to observe in your relationship by the end of treatment).

____
____
____
____
____
____

Provide a brief timeline of your relationship (including important dates or events) and explain in a sentence or two what makes this relationship is meaningful or special to you (i.e., what do you treasure or appreciate most about your history together?).

____
____
____
____
____
____
____
____

What attempts have you made to address concerns with your partner? How does your partner respond & would have you observed any of success at all with these attempts or strategies?

____
____
____
____
____
____
____

Have you been in therapy before? ☐ Yes ☐ No / If yes, please note the when, name of clinician/agency, primary issues addressed, & indicate whether it was helpful.

____
____
____
____

(use the back of this sheet if you need more space for your responses)

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NAME: ____

Reflecting on the last 6 months, please circle all that apply:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Feel more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Excessive gambling
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Take too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm yourself	Strong fears
Thoughts to hurt others	Difficulty with work or school
Feeling ill/sick	Stomach aches/vomiting
Threats to hurt others	Use of painkillers & analgesics
Addiction/Compulsion Behavior (pornography, video games, internet, etc)	

Medical History

Are you currently being treated for any medical problems? ☐ Yes ☐ No
Are you currently taking any medications? ☐ Yes ☐ No
List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? ☐Yes☐ No
Are you presently in good health? ☐Yes ☐ No
Do you engage in physical activity? ☐Yes ☐ No
If yes, what activity? ___________________________ How often?____________

NAME: ____

Do you smoke cigarettes (cigars, chew)? ☐ Yes ☐ No #______per day
How much alcohol do you drink? #__________per day __________# per week
Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many per day?_____
Do you use illicit drugs? ☐ Yes ☐ No
If yes, how often and what drugs do you use?_______________________________________
Have you ever tried to cut down or stop using alcohol or drugs? ☐ Yes ☐ No
Has anyone ever asked you to cut down on your drinking? ☐ Yes ☐ No
Have you ever been hospitalized for any emotional/ mental health condition? ☐Yes☐ No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) ☐ Yes ☐ No
Do you have a history of domestic violence? ☐ Yes ☐ No
Do you have a history of verbal, emotional or physical abuse? ☐ Yes ☐ No
Do you have a history of sexual abuse or sexual assault? ☐ Yes ☐ No
If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)

____
____
____
____

SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	☐ Yes ☐ No	
Do have a religion or spiritual practice that you experience as supportive?	☐ Yes ☐ No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	☐ Yes ☐ No	
Is there a family member that you trust and can go to in times of emotional need?	☐ Yes ☐ No	
Are there other people or aspects of your life that you consider supportive?	☐ Yes ☐ No	

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NAME: ____

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Marriage or Partnership History (fill in blank where applicable):
Length of relationship with Partner:_______________ Length of Engagement:___________________
Number of Previous Relationships that Lasted More Than 6 Months:___________________________
Date of Marriage:______________________ Number of Breakups/Separations:___________________
Length of Separations/Breakups____
____
If this is not your first marriage, please list dates of previous marriages below & primary reasons for divorce:____
____
____
____

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NAME: ____

Intimate Relationship Issue Checklist

Seriousness of Issue

Issue	**Not at all**		**Somewhat Serious**		**Extremely serious**
Communication	1	2	3	4	5
Affection	1	2	3	4	5
Physical Attraction	1	2	3	4	5
Sex	1	2	3	4	5
Religion/Spirituality	1	2	3	4	5
Money/Finances	1	2	3	4	5
In-laws (Partner's Family)	1	2	3	4	5
Friends	1	2	3	4	5
Alcohol/Drug Use	1	2	3	4	5
Children/Parenting	1	2	3	4	5
Roles	1	2	3	4	5
Romance	1	2	3	4	5
Recreation/Companionship	1	2	3	4	5
Career Choice (work schedules)	1	2	3	4	5
Stress	1	2	3	4	5
Health Problems	1	2	3	4	5
Legal Issues	1	2	3	4	5
Domestic Violence	1	2	3	4	5
Emotional/Verbal Abuse	1	2	3	4	5
Commitment/Infidelity/Trust	1	2	3	4	5

List 3 of *your* strengths & describe how each strength impacts the life of your partner:
1.
2.
3.

List 3 of your *partner's* strengths & describe how each strength impacts your life:
1.
2.
3.

Do you find it difficult to assert your feeling or be open & honest with your partner? ☐Yes ☐No
If Yes, please attempt to explain:____
____
____
____
____
____

NAME: ____

Do you have children? If yes, please complete box below:

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Addison, TX 75001
Jantel Jordan, Psy.D./413-798-4522/GREATLIFECONSULTS.COM

Name	Date of Birth	Age	Where does child reside?

Do any of your children have special needs? ____
Does anyone else currently live in the home? If yes, what is their relationship to you?______
____
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Please note any other issues that you think or feel would be good for your psychologist to know:
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~ Thank you ~

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COUPLES THERAPY INTAKE QUESTIONNAIRE

(*EACH PARTNER NEEDS TO COMPLETE THIS FORM SEPARATELY)*

NAME: ____

What brought you into therapy at this time (i.e., what events or conversations prompted the action)?
____
____
____
____
____
____

What do you wish to change or accomplish as a result of therapy? (Describe 3 improvements you hope to observe in your relationship by the end of treatment).
____
____
____
____
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____

Provide a brief timeline of your relationship (including important dates or events) and explain in a sentence or two what makes this relationship is meaningful or special to you (i.e., what do you treasure or appreciate most about your history together?).
____
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What attempts have you made to address concerns with your partner? How does your partner respond & would have you observed any of success at all with these attempts or strategies?
____
____
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____

Have you been in therapy before? ☐ Yes ☐ No / If yes, please note the when, name of clinician/agency, primary issues addressed, & indicate whether it was helpful.
____
____
____
____

(use the back of this sheet if you need more space for your responses)

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NAME: ____

Reflecting on the last 6 months, please circle all that apply:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Feel more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Excessive gambling
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Take too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm yourself	Strong fears
Thoughts to hurt others	Difficulty with work or school
Feeling ill/sick	Stomach aches/vomiting
Threats to hurt others	Use of painkillers & analgesics
Addiction/Compulsion Behavior (pornography, video games, internet, etc)	

Medical History

Are you currently being treated for any medical problems? ☐ Yes ☐ No
Are you currently taking any medications? ☐ Yes ☐ No
List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? ☐Yes☐ No
Are you presently in good health? ☐Yes ☐ No
Do you engage in physical activity? ☐Yes ☐ No
If yes, what activity? __________________________ How often?____________

NAME: ____

Do you smoke cigarettes (cigars, chew)? ☐ Yes ☐ No #______per day
How much alcohol do you drink? #__________per day __________# per week
Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many per day?_____
Do you use illicit drugs? ☐ Yes ☐ No
If yes, how often and what drugs do you use?_____________________________________
Have you ever tried to cut down or stop using alcohol or drugs? ☐ Yes ☐ No
Has anyone ever asked you to cut down on your drinking? ☐ Yes ☐ No
Have you ever been hospitalized for any emotional/ mental health condition? ☐Yes☐ No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) ☐ Yes ☐ No
Do you have a history of domestic violence? ☐ Yes ☐ No
Do you have a history of verbal, emotional or physical abuse? ☐ Yes ☐ No
Do you have a history of sexual abuse or sexual assault? ☐ Yes ☐ No
If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)

____
____
____
____

SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	☐ Yes ☐ No	
Do have a religion or spiritual practice that you experience as supportive?	☐ Yes ☐ No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	☐ Yes ☐ No	
Is there a family member that you trust and can go to in times of emotional need?	☐ Yes ☐ No	
Are there other people or aspects of your life that you consider supportive?	☐ Yes ☐ No	

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NAME: ____

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Marriage or Partnership History (fill in blank where applicable):
Length of relationship with Partner:_______________ Length of Engagement:___________________
Number of Previous Relationships that Lasted More Than 6 Months:___________________________
Date of Marriage:______________________ Number of Breakups/Separations:___________________
Length of Separations/Breakups____
____

If this is not your first marriage, please list dates of previous marriages below & primary reasons for divorce:____
____
____
____

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NAME: ____

Intimate Relationship Issue Checklist

Seriousness of Issue

Issue	Not at all		Somewhat Serious		Extremely serious
Communication	1	2	3	4	5
Affection	1	2	3	4	5
Physical Attraction	1	2	3	4	5
Sex	1	2	3	4	5
Religion/Spirituality	1	2	3	4	5
Money/Finances	1	2	3	4	5
In-laws (Partner's Family)	1	2	3	4	5
Friends	1	2	3	4	5
Alcohol/Drug Use	1	2	3	4	5
Children/Parenting	1	2	3	4	5
Roles	1	2	3	4	5
Romance	1	2	3	4	5
Recreation/Companionship	1	2	3	4	5
Career Choice (work schedules)	1	2	3	4	5
Stress	1	2	3	4	5
Health Problems	1	2	3	4	5
Legal Issues	1	2	3	4	5
Domestic Violence	1	2	3	4	5
Emotional/Verbal Abuse	1	2	3	4	5
Commitment/Infidelity/Trust	1	2	3	4	5

List 3 of *your* strengths & describe how each strength impacts the life of your partner:
1.
2.
3.

List 3 of your *partner's* strengths & describe how each strength impacts your life:
1.
2.
3.

Do you find it difficult to assert your feeling or be open & honest with your partner? ☐Yes ☐No
If Yes, please attempt to explain:____
____
____
____
____
____

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NAME: ____

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~ Thank you ~