

Great Life Counseling Center
14275 Midway Rd., Ste. 260
Addison, TX 75001
Sam Reyna, Ph.D./469-573-4522/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. **Supervisory Disclosure & Notice of Video Recording**
(each person must sign)
6. **Intake Questionnaires**
(each person needs to privately complete his/her own)

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DEMOGRAPHIC/FINANCIAL RESPONSIBILITY 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

CPT Code 90837 + 90785 (55-60 min).....\$165/hour

Additional psychotherapy session time will be 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 fees15 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).....\$250/hour (pro-rated)

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 A Signature: _____ **Date:** _____

Client/Partner B Signature: _____ **Date:** _____

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

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 _____

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.

My Philosophy

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 & celebrations as well as difficulties & 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 self, family & community, and the world-at-large. Tools & information gained from the psychologist's many years of formal education & professional experience will be shared when it is relevant & appropriate. However, some of the most powerful breakthroughs or revelations often come from the psychologist's facilitation of self-discovery, improved communication or understanding of relationships, and skill development. 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.

About the Therapy Process

It is important to acknowledge that therapy has both benefits and risks. Couples Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience some feeling of discomfort or distress. However, therapy has been shown to have great benefits for those who are willing to make such an investment in their relationship. Although there are no guarantees about the outcomes of therapy, couples often report significant reductions in feelings of distress, greater understanding of their relationship & their partner, satisfactory resolution of specific problems, and an overall improvement in quality of life.

Similar to any other relationship, therapy is most effective when the interpersonal chemistry, collaboration & candor between the clients and therapist are healthy & evident during each interaction. Working toward these benefits does require significant effort on the part of the clients including their very active involvement, honesty, openness, consistent attendance to appointments, and follow through on recommendations. The psychologist's role is to utilize his expertise to help the couple listen and communicate with each other more effectively, develop & better utilize resources for their relationship, and better understand & address current or potential dysfunction. Clients are encouraged to make efforts to be self-reflective, forthright & honest with therapist, 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 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.

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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

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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/oct/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.

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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 A signature _____ Date _____

Client/Partner B signature _____ Date _____

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

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**Supervisory/Consultation Disclosure Form
&
Notice of Video Recording**

Samuel Reyna, Ph.D. is a Provisionally Licensed Psychologist at Great Life Counseling Center. In order to become a Provisionally Licensed Psychologist for Great Life Counseling Center, Dr. Reyna had to achieve his doctorate in the field of psychology along with at least 5 years of experience practicing at other clinical sites, complete a postdoctoral fellowship year, and pass the Examination for the Professional Practice of Psychology (E.P.P.P.). Dr. Reyna is now eligible for full licensure as a Texas licensed psychologist but she is still waiting for his application to be processed by the Texas State Board of Examiners of Psychologists. In the meantime, she must be supervised by a Texas licensed psychologist in good standing.

In order to ensure the highest standard of care, Dr. Reyna and his primary supervisor will meet weekly to discuss and review Dr. Reyna's documented work with you. As a Great Life clinician under supervision, Dr. Reyna is encouraged to video record most sessions and present select sessions to his primary supervisor for review. At times, these video recordings may be used to aide case consultation with the Great Life Counseling Center clinical team. All recordings are destroyed or deleted following the primary supervisor's review or team consultation (not to exceed 4 weeks from the date of the session). 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 this 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. Reyna or his primary supervisor 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 his 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 and/or video recording at any time.

Therapist's Name: Samuel Reyna, Ph.D.

Primary Supervisor's Name: Kevin C. Lambert, Psy.D.

Secondary Supervisors' Names: Nikki Stillo, Ph.D. and Blair Kenney, Psy.D.

Client (or Guardian) Signature: _____ Date: _____

Client (or Guardian) Signature: _____ Date: _____

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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.

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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? _____

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NAME: _____

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

<p>Have you experienced or witnessed a traumatic event? (<i>parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one, etc</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a history of domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a history of verbal, emotional or physical abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a history of sexual abuse or sexual assault? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered ‘Yes’ to any of the questions in this box, please provide the general details below (including date/duration of events)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

SUPPORT SYSTEMS

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

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

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? _____

Please note any other issues that you think or feel would be good for your psychologist to know:

~ Thank you ~

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(EACH PARTNER NEEDS TO COMPLETE THIS FORM SEPARATELY)

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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.

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NAME: _____

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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? _____

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NAME: _____

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

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

SUPPORT SYSTEMS

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

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

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? _____

Please note any other issues that you think or feel would be good for your psychologist to know:

~ Thank you ~