Client Intake Form

General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May we contact you via email? ☐ Yes ☐ No

Would you like to be added to our email list? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Spirituality

Insurance Information

Primary Insurance | Phone Number

Insured Name | DOB | SSN #

Member Number | Group Number | Employer Name

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Spouse/Partner | Age | Lives with you? ☐ Y ☐ N

How satisfied are you with your relationship? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No If no, please skip to the next section.

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Family History

Who were you raised by?

How many siblings do you have?

Please describe your relationship with your parents/caregivers:

Please describe any mental health diagnosis within your family (grandparents, parents, siblings):

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, pease explain why:

Employment/Education Status

Employer/School

Occupation/Years in School

Please check all that apply:

☐ Disabled ☐ Employed Part Time ☐ Unemployed
☐ Employed Full Time ☐ Retired ☐ Student

What is your highest level of education completed?

☐ Less Than High School ☐ Associates Degree ☐ Bachelor's Degree
☐ High School/GED ☐ Some College ☐ Post Graduate Degree

Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming Others
- ☐ Violence
- ☐ Weight Gain/Loss

Have you experienced abuse? ☐ Yes ☐ No

If yes, please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist Dates seen

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Have you had any surgeries or operations? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician Phone Number

Permission to contact physician? ☐ Yes ☐ No

Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Abuse
- ☐ Attempted Suicide
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Unemployment
- ☐ Frequent Relocations
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Other _____

Personal History

What symptoms are you dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Thoughts of Self-harm/Suicide
- ☐ Trouble Sleeping
- ☐ Other _____

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often:

Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No

If yes, what are they and how often do you do them?

What do you do for fun?

Legal Summary

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Fraud
- ☐ Substance Abuse
- ☐ Driving Offenses
- ☐ Immigration
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here: Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?

Payment Informaton & Authorization

Payment Information

Amount

☐ Cash ☐ Check ☐ Credit Card

Credit Card Authorization

Please complete all of the fields below if you plan on paying by credit card. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Name on Card

Zip Code

Credit Card Number

Card Expiration

Card Type ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other

By signing below, I authorize WCT Health & Wellness to charge the credit card above for agreed-upon purchases and fees. I understand that my information will be saved for future transactions on my account.

Name Printed

Signature

Date

Cancellation & No Show Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 48 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone at info@wctbehavioral.com

ALL NO-SHOWS AND ANY APPOINTMENTS CANCELLED, RESCHEDULED, OR CHANGED WITHOUT 48 HOURS' NOTICE WILL BE BILLED TO YOUR ACCOUNT IN THE AMOUNT WE WOULD HAVE COLLECTED IF THE SERVICE HAD BEEN PROVIDED AS SCHEDULED.

Please keep in mind that insurance does not reimburse for missed appointments; therefore, you will be responsible for the full payment of the appointment fee. For example, if a therapy session is $100, and you have a $35 copay you would be responsible to pay $100 for a late cancellation or missed appointment.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

ARRIVAL TIME

Please arrive at your appointment at least 5 minutes prior to your scheduled appointment time. All therapy has a specific time schedule. An early arrival allows for a relaxed experience. If you arrive late, your therapy may be shortened in order to maintain our schedule.

LATE ARRIVAL POLICY

All appointments begin and end on time in order to maintain our schedule. If the therapy does not start on time due to client tardiness, the therapy time will be reduced accordingly and you will still be required to pay full price. If a client is more than 15 minutes late, the appointment will be considered a cancellation.

I have read and understood the cancellation and refund policy and agree to abide by the above conditions.

Name Printed	Signature	Date

Informed Consent for Counseling and Psychotherapy

This informed consent document is intended to provide general information about the counseling services provided by WCT Health & Wellness. This is a legal document; please read it carefully before signing.

Mental Health Services

WCT Health & Wellness recognizes that it may not be easy to seek help from a mental health professional. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result

Nature of Therapy & Risks

It is important to understand that there are both benefits and risks associated with participation in therapy. Therapy may improve the ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. However, clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. Therapy can lead to unanticipated feelings and change, which might have an unexpected impact on you, and your relationships. For example, marital therapy may lead to the possibility of exercising the divorce option.

Relationship

The relationship you have with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. It is not appropriate to share gifts, barter, or trade services with your therapist.

Confidentiality

Discussions between you and your therapist are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist when you and the therapist discuss this matter further.

After-Hour Concerns & Emergencies

As a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, you may contact your therapist in between sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Communication

By signing the Informed Consent for Counseling and Psychotherapy document, you are consenting for WCT Health & Wellness to communicate with you by phone, e-mail, and at the address provided on your client intake form. You agree to notify us if you need to opt out of any form of communication.

Fees

- The fee for individual therapy sessions are $100 per session and are approximately 55 minutes in length.
- The fee for conjoint (marital /family) therapy sessions are $125 per session and approximately 55 minutes in length.
- The fee for group therapy sessions are $50 per session and approximately 50 minutes in length.
- Fees are payable at the time that services are rendered.
- If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Insurance

Please talk to your therapist if you plan to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Ultimately, the financial responsibility is yours and you will be required to pay for services in the event that your insurance does not cover them. Please discuss any questions or concerns that you may have about this with your therapist.

Consent to Treat

By signing the Informed Consent for Counseling and Psychotherapy, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services and that you may stop such care, treatment, or services at any time. By signing the Informed Consent for Counseling and Psychotherapy document you acknowledge that you have both read and understood all the terms and information contained herein. You also agree that you have had the opportunity to ask questions and seek clarification of anything that remains unclear and that those questions have been answered satisfactorily.

Your signature below indicates that you have read this agreement for services carefully and understand its contents.

Name Printed	Signature	Date