Wood Christian Counseling
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2003 Rickety Ln., Suite B
Tyler, Texas 75701 (903) 283.8729

Client Intake Form

Date: _____

Client: _____**DOB** _____**Age:**_____
Address: _____**City:** _____
State: _____**Zip Code:** _____
Home Phone: _____**Cell:** _____**Work:** _____
Social Security: _____ **Occupation:** _____
Marital Status: _____**Months / Years:** _____
Anniversary Date: _____
Which phone would be best to contact you? _____
How were you referred to us? _____

Spouse / Guardian: _____**DOB:** _____**Age:** _____
Address: _____**City:** _____
State: _____**Zip Code:** _____
Home Phone: _____**Cell:** _____**Work:** _____
Social Security: _____ **Occupation:** _____
Marital Status: _____**Months/ Years:** _____

Family Information

Please list any family members / dependents living in your home including age and relationship:

Name:	**DOB:**	**Relationship:**
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Name:	**DOB:**	**Relationship:**

Treatment

Previous / Current Counseling History ( ) yes ( ) no If yes, please explain (including dates):

Previous / Current Psychiatric Treatment: ( ) yes ( ) no If yes, please provide treating MD name, telephone #, and list of medication:

History of hospitalization for substance abuse or any other psychiatric disorder: ( ) yes ( ) no If yes, please explain (including dates):

Please describe any medical or health problems:

Have you been previously married? ( ) yes ( ) no

Current Symptoms (May put initials)

_____Jealousy	_____Financial Issues
_____Abandonment	_____Intimacy problems
_____Depression	_____Infidelity Issues
_____Withdrawn	_____Sexual Problems
_____Lack of Communication	_____Suicidal Thoughts
_____Spiritual Issues	_____Eating Issues
_____Panic Attacks or Anxiety	_____Drug or Alcohol Abuse
_____Fearful / Phobias	_____Nightmares
_____Impulsive or Controlling behaviors	_____Rage / Anger

Have you ever contemplated or attempted suicide? ( ) yes ( ) no If yes, please explain, including time frame.

Current or Previous History of Domestic Violence including verbal or physical? ( ) yes ( ) no If yes, please explain

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Please list emergency contacts:

Name: _____ Relationship: _____Phone #: _____

Name: _____ Relationship: _____Phone #: _____

Confidentiality, Consent to Treatment, and Treatment Policies

- **I understand that everything discussed during counseling is held confidential, with the exception if the counselor suspects that I intend to hurt myself or someone else, if a report is made about any physical or sexual abuse of a minor child or of an elder, or if records are requested by a court of law in order to testify to those records.**
- **I understand that it is my responsibility to make the counselor aware of any schedule changes, and if I fail to give a 24 hour notice of cancellation I will be charged. I understand that insurance will unlikely reimburse me for this charge.**
- **I understand that I am over 20 minutes late for an appointment, the session is considered a "no show" and I will be charged.**
- **I understand if a check bounces, I will be charged a $25.00 service charge. After 2 times, I will need to pay in cash.**
- **I understand if I am billing insurance and they refuse to pay, I am responsible for the total amount due.**
- **I understand that I am responsible for the full session payment or my co-payment at the time of my appointment.**
- **I understand that I will receive a receipt after every sessions for services provided.**
- **I understand that if I have an emergency I should call 911 directly.**

I have read, and I understand all of the policies that are listed above.

_____ _____

Signature of Client / Parent / Guardian (please circle) **Date**

_____ _____

Signature of Counselor **Date**