Katy Center for Psychology & Counseling Services

Adult Intake

Couples Format

Please take the following lines to explain how we can best help you on your journey right now or what leads you to seek services now (we will go into this in more detail at your visit):

A. Identification Information

Name 1:_____ DOB:_____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

May we leave messages at these numbers? ❑ No ❑ Yes

Email: _____May we send emails to this address: ❑ No ❑ Yes

Name 2:_____ DOB:_____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

May we leave messages at these numbers? ❑ No ❑ Yes

Email: _____May we send emails to this address: ❑ No ❑ Yes

B. Referral:
How did you find out us (please circle one)? Friend Relative Advertisement Seminar
Other: _____

C. Previous Psychological Treatment:
Have either you, personally, received previous individual psychological treatment? ❑ No ❑ Yes
If "Yes" please provide the following information:

Name	When	Duration	By Whom	For What	Results

Have you taken medications for mental health purposes? ❑ No ❑ Yes
If "Yes" please provide the following information:

Name	Medication	When	Duration	By Whom	For What	Results

Previous Psychological Treatment:
Have you received previous psychological treatment for couple's issues? ❑ No ❑ Yes
If "Yes" please provide the following information:

Name	When	Duration	By Whom	For What	Results

D. Relationships:

Name 1: _____
Describe your relationship with your mother in the past and present:

Describe your relationship with your father in the past and present:

Describe your relationship with your sibling(s) in the past and present:

Describe your relationship with your most recent significant other/spouse/partner and the duration of this relationship and name of the person:

Describe the nature of your closest friendships, duration, qualities, and such:

Name 2: _____
Describe your relationship with your mother in the past and present:

Describe your relationship with your father in the past and present:

Describe your relationship with your sibling(s) in the past and present:

Describe your relationship with your most recent significant other/spouse/partner and the duration of this relationship and name of the person:

Describe the nature of your closest friendships, duration, qualities, and such:

E. Mental Health History:

Has anyone in your family been diagnosed with a mental health disorder including addiction(s)?
❑ No ❑ Yes

If yes, please provide the following information:

Name	Who	Diagnosis	When	Treatment Sought?	Results

F. Abuse History

Were either or both of you abused as a minor? ❑ No ❑ Yes

If you were abused, please provide the following information using these letters for the Abuse Type:

P = Physical such as beating, slapping, pushing
S = Sexual such as touching, molesting, fondling, or intercourse
N = Neglect such as failure to feed, shelter, protect, provide medical treatment
V = Verbal such as name-calling, shaming, belittling

Name	Your Age	Abuse Type	By Whom	Effects on you	Whom did you tell	Consequences of telling

G. Primary Adult Relationship History

Name 1: _____

Current marital status: ___Married ___Divorced ___Single ___Widowed

If widowed, please provide the following information:

Marriage	Your age when began	Years Married	Cause of spouse's death	Number of children and ages
1				
2				
3				

If divorced, please provide the following information:

Marriage	Your age when began	Your age when ended	Was divorce high-conflict?	Reason for ending
1				
2				
3				

Are there children from divorced marriage(s)? ❑ No ❑ Yes

If yes, please provide following information:

Marriages	Number of children	Ages	Who has custody?	
1				
2				
3				

Name 2: _____

Current marital status: ___Married ___Divorced ___Single ___Widowed

If widowed, please provide the following information:

Marriage	Your age when began	Years Married	Cause of spouse's death	Number of children and ages
1				
2				
3				

If divorced, please provide the following information:

Marriage	Your age when began	Your age when ended	Was divorce high-conflict?	Reason for ending
1				
2				
3				

Are there children from divorced marriage(s)? ❑ No ❑ Yes

If yes, please provide following information:

Marriages	Number of children	Ages	Who has custody?	
1				
2				
3				

H. Education Information:

Name 1: _____
Highest level of education received: _____ Year:_____
Degree(s) received: _____

Name 2: _____
Highest level of education received: _____ Year:_____
Degree(s) received: _____

I. Employment Information:

Name	Job Title	Dates Held	Employer	Reason for leaving

J. Religious Identification:
Do you both share a spiritual belief system: ❑ No ❑ Yes
Religious affiliation/denomination:_____
Involvement: ___None ___Some/Irregular ___Active
How important are spiritual concerns in your life?_____
Do you want spiritual topics/concerns incorporated into your treatment?_____

K. Chemical Use: Please answer completely and honestly

Name 1: _____
How many alcoholic drinks (including wine and beer) do you consumer/week?_____
Has alcohol consumption ever created problems in your life? ❑ No ❑ Yes
If yes, please explain: _____
_____
_____

_____

Have others ever complained to you about your alcohol consumption? ❑ No ❑ Yes
Do you smoke cigarettes? ❑ No ❑ Yes If yes, how many packs/day? _____

Please provide complete and honest answers below regarding illegal substance use:

Chemical	Last use	Amount	How often used	How long used
Marijuana				
Cocaine/Crack				
Inhalants				
LSD				
Prescribed pills				
Heroin				
Specify Other				

Which if these have you experienced due to alcohol and/or illegal substance use:
___Blackouts ___Withdrawal symptoms ___Cravings ___Overdoses ___N/A

Have you ever been treated (including hospitalization) for alcohol and/or illegal substance use/abuse? ❑ No ❑ Yes
If yes, please provide the following information:

Dates	Agency	Type of Program	Voluntary? Yes/No	Length of Treatment	Effects of Treatment

Have you ever experienced legal problems (including arrest) due to alcohol and/or use of illegal substances? ❑ No ❑ Yes
If yes, please explain: _____
_____
_____
_____

Name 2: _____

How many alcoholic drinks (including wine and beer) do you consumer/week?_____

Has alcohol consumption ever created problems in your life? ❑ No ❑ Yes

If yes, please explain: _____

_____

_____

_____

Have others ever complained to you about your alcohol consumption? ❑ No ❑ Yes

Do you smoke cigarettes? ❑ No ❑ Yes If yes, how many packs/day? _____

Please provide complete and honest answers below regarding illegal substance use:

Chemical	Last use	Amount	How often used	How long used
Marijuana				
Cocaine/Crack				
Inhalants				
LSD				
Prescribed pills				
Heroin				
Specify Other				

Which if these have you experienced due to alcohol and/or illegal substance use:

___Blackouts ___Withdrawal symptoms ___Cravings ___Overdoses ___N/A

Have you ever been treated (including hospitalization) for alcohol and/or illegal substance use/abuse? ❑ No ❑ Yes

If yes, please provide the following information:

Dates	Agency	Type of Program	Voluntary? Yes/No	Length of Treatment	Effects of Treatment

Have you ever experienced legal problems (including arrest) due to alcohol and/or use of illegal substances? ❑ No ❑ Yes

If yes, please explain: _____

_____

L. Health Information

Starting with childhood and proceeding to the present, list all major diseases, illnesses, important accidents and injuries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had not including pregnancies.

Name	Age	Illness/Diagnosis	Length of Illness	Medications Taken	Effects of Treatment

Name 1: _____

How many hours sleep/night do you average?_____

Is this consecutive or broken sleep?_____

How many hours of exercise do you average/week?_____

What is your exercise of choice?_____

How many meals do you average/day?_____

Would you describe your diet as poor, average, healthy?_____

Name 2: _____

How many hours sleep/night do you average?_____

Is this consecutive or broken sleep?_____

How many hours of exercise do you average/week?_____

What is your exercise of choice?_____

How many meals do you average/day?_____

Would you describe your diet as poor, average, healthy?_____

<u>For women only:</u>

Do you struggle with your weight? ❑ No ❑ Yes

If yes, how and what efforts have you made to lose and/or maintain your weight?

_____

_____

_____

How many pregnancies have you had?_____

Have you had any miscarriages or abortions? ❑ No ❑ Yes

If yes, how many and when:_____

Menstrual period questions:

How regular are your periods?

What are your primary PMS symptoms?_____

_____

_____

What types of hormonal treatments/medications have you or are you currently taking?

Menopause questions:

If you are in menopause, what age did it start?

What age did it finish?

What types of hormonal treatments/medications have you or are you currently taking?

M. Presenting Symptoms: Please mark all of the items below that apply to you, using your initials. Both of you should go through this list independently and mark your choices. Feel free to add any others at the bottom under "Other concerns or issues." You are welcome to add a note or details next to those you mark.

___Abuse experienced: physical, sexual, emotional, neglect
___Aggression, violence
___Alcohol use/abuse/addiction
___Anger, hostility, arguing, irritability
___Anxiety, nervousness
___Attention, concentration, distractibility
___Career goals, concerns, and choices
___Childhood issues (your own)
___Codependence
___Confusion
___Custody battle regarding children, visitation conflicts
___Decision making, indecision, mixed feelings
___Delusions
___Dependence
___Depression, low mood, sadness, crying
___Divorce, separation
___Drug use – prescription, over-the counter, illegal substances
___Eating problems – overeating, under eating, vomiting
___Emptiness
___Failure
___Fatigue, tiredness, low energy
___Fears, phobias
___Financial troubles, debt, impulsive spending, low income
___Friendships
___Gambling
___Grieving, mourning, deaths, losses, divorce
___Guilt

___Headaches, other kinds of pain_____
___Health, illness, medical concerns, physical problems
___Housework, chores – quality, schedules, sharing duties
___Inferiority feelings
___Interpersonal conflicts
___Impulsiveness, loss of control, outbursts
___Irresponsibility
___Judgment problems, risk taking
___Legal matters, charges, suits, probation
___Loneliness
___Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
___Memory problems
___Menstrual problems, PMS, menopause
___Mood swings
___Motivation (lack thereof), laziness
___Nervousness, tension
___Obsessions, compulsions (thoughts or actions that repeat themselves)
___Oversensitivity to rejections
___Panic or anxiety attacks
___Parenting, child management, single parenthood
___Perfectionism
___Pessimism
___Procrastination, work inhibitions
___Relationship problems (with friends, relative, co-workers)
___School problems
___Self-centeredness
___Self esteem
___Self-neglect, poor self-care
___Sexual issues, dysfunctions, conflicts, desire differences
___Shyness, oversensitivity to criticism
___Sleep problems – too much, too little, insomnia, nightmares
___Smoking and tobacco use
___Spiritual, religious, moral ethical issues
___Stress, inability to relax, stress management, tension
___Suspiciousness
___Suicidal thoughts
___Temper problems, low frustration tolerance, violent tendencies
___Thought disorganization, confusion
___Weight and diet issues
___Withdrawal, isolating
___Work problems, unemployment, workaholism, inability to keep job

Other concerns or issues:_____
_____

Of the concerns you noted, which one is of the most concern_____
_____

What results would you like to see in therapy?_____

_____

_____

When was the last time you considered yourselves happy and/or content?_____

_____

What are your current hobbies?_____

_____

What else is important for your clinician to know?_____

_____

_____

Thank you for the time and effort you have spent in completing this Intake form!

Katy Center for Psychology & Counseling Services

CREDIT CARD AUTHORIZATION
Please make no marks or add comments to this page of the document.

It is your consent to make payment for services rendered and time allotted for your treatment or assessment and these professional services are conditional on your signing this consent form without modification. This form will be securely stored in your client file and may be updated upon request at any time.

If you miss or fail to cancel an appointment within 48 business hours of the scheduled time, or if a check is returned unpaid, you will be charged for the time allotted for your appointment. With appropriate notice, appointment slots can almost always be used to serve another client. An additional $25 fee will be assessed for returned checks or inaccurately disputed charge-backs.

I, _____, hereby authorize Dr. Alexis Llewellyn or Katy Center for Psychology & Counseling Services to charge my credit card at a rate of $200 per hour for the individual time allotted me and $225 per hour for couples or family appointments per hour allotted to us including all of the following:

*Missed appointments/no shows
*Appointments that I have cancelled with less than 48 business hours notice
*Returned checks or chargebacks from PayPal in which an additional $25 will be added to the total

Credit Card/Debit Card Type (check one):

□ Visa □MasterCard □Discover □American Express

Card #_____ Expiration Date: _____

Verification/Security Code (3-digit code on back of card or 4-digit code on front):_____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Email address that may be used to send notification of payment: _____

By signing below I am authorizing Dr. Alexis Llewellyn or Katy Center for Psychology & Counseling Services to charge my credit card for professional services as described above. I understand that credit card transactions require release of some of my identifying information and consent to this release. I certify that I am the owner of the credit card listed on this page and can thereby authorize this card to be charged:

Signature: _____ Date: _____

Printed Name: _____