



Date of First Appointment: ____/____/____

Client Contact Information:		
Full Name of Client:	Birth Date: / /	Age:
Street Address:		
City:	State:	Zip:
Parent or Guardian Name(s) - - if client is a minor:		
Check box if okay to leave messages		
Home Phone: <input type="checkbox"/>	Cell Phone: <input type="checkbox"/>	
Work Phone: <input type="checkbox"/>	Email: <input type="checkbox"/>	
Client Billing Information:		
Billing Address (if different than above):		
Emergency Contact:		
Name:	Phone:	
Relationship to Client:	Alternative Phone:	
Referred By:		
<input type="checkbox"/> Physician	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Therapist
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Website
<input type="checkbox"/> Other _____		



CONSENT TO TREATMENT & FINANCIAL AGREEMENT

I, _____ (name of client or guardian), agree and consent to the policies, procedures, fees, and payment arrangements as stated in the *Policies & Procedures* document provided. I understand that payment is collected at the time of service and that cancellations must be made 24 hours in advance to avoid a charge to my account. I understand that Vienna Counseling and its providers are not affiliated with any insurance companies and that it is my responsibility to seek out-of-network reimbursement should I choose to do so. I acknowledge and accept full responsibility for this account and guarantee payment of all charges against it. I have been given a copy of the *Notice of Privacy Practices (HIPPA)* document and agree and consent to the information provided.

Minor Consent: Please check this box if the client is under the age of eighteen or unable to consent to treatment and you are signing as the guardian. By doing so, you attest that you have legal custody of this individual and are authorized to initiate and consent for treatment on behalf of this individual.

Your signature below indicates that you have read the information provided and understand and agree to abide by the terms and conditions.

Print Client Name

Client Date of Birth

Signature of Client or Guardian

Date Signed



CLIENT INTAKE INFORMATION

Legal Name: _____

Date: _____

Preferred Name: _____

Please answer the following questions, which will help me to obtain accurate background information that will be useful in our work together. Please skip any questions that you are not comfortable with or ready to answer, and feel free to discuss any concerns you have regarding this document in your next session. Information obtained in this document will be kept strictly confidential in compliance with HIPPA regulations.

PROBLEM ANALYSIS

1. **PROBLEM DESCRIPTION:** Briefly describe the problem(s) and symptom(s) for which you are currently seeking help.

2. **PROBLEM DURATION:** Approximately how long have you had the current problem(s)? _____

3. **PRECIPITATING EVENTS:** Were there any precipitating events (e.g. major family illness or death, divorce, moving to a new residence, etc.)?

4. **COPING ATTEMPTS:** In what ways have you attempted to cope with this problem?

5. Have you had any difficulty falling or staying asleep recently? If so, briefly describe. **Yes / No**

6. Have you had any recent changes in eating or appetite, or problems with your eating habits? If so, briefly describe. **Yes / No**

7. Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

Yes No

8. Have you had previous psychological counseling? Yes No

If yes, to the best of your ability please note the your age and duration of previous counseling experience(s):

9. Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, what hospital, approximate dates, precipitating event:

10. Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes No

If yes, please list medication, dosage, and the approximate date treatment began:

<i>Medication</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Approx Date Began</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. If not currently prescribed medication, have you been prescribed such medications in the past?

Yes No

If yes, please list medication, dosage, and the approximate date treatment began and ended:

<i>Medication</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Approx Dates</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Are you currently taking any other prescribed medication (e.g., for hypertension, migraines, etc.)?

Yes No

If yes, please list medication, dosage, and the approximate date treatment began:

<i>Medication</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Approx Date Began</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Please list any current or on-going physical symptoms, chronic illnesses, or other health concerns or conditions (e.g. chronic pain, headaches, fibromyalgia, diabetes, etc.):

WORK & EDUCATIONAL HISTORY

1. List your current or most recent job/employment, along with your title/position. If student, please list school and current grade.

2. List the most recent education you have received (e.g., high school, vocational school, college).

HEALTH RELATED ISSUES

1. How many times per week do you exercise? _____ For about how long each time? _____

2. Do you regularly use alcohol? **Yes / No**

How often do you use alcohol? _____

What do you typically drink? _____

Have you used more alcohol than you intended this year? **Yes / No**

Have you ever felt the need to cut down on the amount of alcohol you drink? **Yes / No**

Do you consider your alcohol consumption a problem? **Yes / No Unsure**

3. How often do you engage in recreational drug use?

Daily

Weekly

Monthly

Rarely

Never

Have you ever felt the need to cut down on the amount of drugs you use? **Yes / No**

List any recreation drugs you currently use and how often you use them:

Do you consider this drug use a problem? **Yes / No Unsure**

4. Is there a history or alcohol/substance abuse or dependence in your family? **Yes / No** (If yes, please specify)

5. Is there a history or mental health concerns or mental illness in your family? **Yes / No** (If yes, please specify)

6. Do you have any problems or worries about sexual functioning? **Yes / No** (If yes, circle applicable response):

Lack of desire Performance Problem Sexual Impulsiveness Difficulties Maintaining Arousal

Worried about STDs (Sexually Transmitted Diseases) Other _____

SOCIAL HISTORY AND OTHER ISSUES

1. Describe your relationship status: Single Domestic Partner Married Divorced Widowed

Other (*specify*): _____

2. Gender identity & preferred pronouns: _____

3. Sexual orientation: _____

4. Describe your living situation (with whom, type of housing, etc.) below:

5. List any family members that are currently a source of support for you:

6. List any friends that are currently a source of support for you:

7. List any other sources of support (i.e. Church, activities, etc.):

8. Have you ever experienced or witnessed domestic violence or abuse? **Yes / No**

9. Have you ever experienced sexual abuse, assault, or uncomfortable touching? **Yes / No**

10. Have you had suicidal thoughts recently? **Yes / No** (If yes, circle applicable response):

Frequently Sometimes Rarely Never

11. Have you had suicidal thoughts in the past? **Yes / No** (If yes, circle applicable response)

Frequently Sometimes Rarely Never

12. Have you ever attempted suicide? **Yes / No** (If yes, please list the age(s) of the attempt(s)) _____

13. Have you ever intentionally inflicted any other form of harm upon yourself? **Yes / No**

14. Have you intentionally inflicted any form of harm upon anyone else recently? **Yes / No**



ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through Vienna Counseling. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept Visa, MC, and Discover.

Client Information:

Client Name: _____

Billing Address: _____

Email: _____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card).

Please enter the CVV code: _____ (last three digits on back of card)

I understand that this form authorizes my provider to charge the card for varying session types, across multiple dates of service. By authorizing use of this card, and signing the electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature

Date

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA Association, Buffalo, NY.

Credit/Debit Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card Number: _____ Expiration Date: _____