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**WAKE FOREST
MIND AND HEALTH, PLLC**
An Integrated Approach to Wellness
COUNSELING ~ COACHING
BIOFEEDBACK ~ STRESS MANAGEMENT

Couples / Marriage Counseling Intake Form

Today's Date: _____

SPOUSE / PARTNER ONE TO COMPLETE THIS SECTION SEPARATELY

Name: _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female Non-Binary

Ethnicity: Black White Asian Hispanic / Latinx Native American Other: _____

STUDENT / EMPLOYMENT STATUS:

Full-Time Employed Part-Time Employed Homemaker / Caretaker Legally Disabled

Unemployed Retired Full-Time Student Part-Time Student Active Volunteer

Length of Employment: _____ Retirement / Unemployment Date: _____

School and Grade or Major / Degree: _____

Employer Name and Position: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION:

Mailing Address:

Physical Address (If Different):

May I send mail to the above mailing address? Yes No

Telephone Numbers / Email Address (Please provide only numbers at which you give me permission to call you):

Home: _____
Work: _____
Cell: _____
Email*: _____

May I leave a message? Yes No
May I leave a message? Yes No
May I leave a message? Yes No
May I email you? Yes No

*Please be aware that email might not be confidential.

Name of Contact Person in Case of Emergency: _____

Telephone #: _____ **Relationship:** _____

MENTAL HEALTH HISTORY:

1. Are you currently receiving psychotherapy elsewhere? Yes No
2. Have you ever had psychotherapy in the past? Yes No
3. If yes, previous therapist's name to either question above: _____
When? _____ Duration of treatment: _____
Focus of treatment / presenting issue: _____
4. May I contact your primary care / referring physician to coordinate care? Yes No
5. In the past year, have you experienced any significant life changes, stressors, loss / grief, crisis, or trauma? Yes No
If yes, please describe: _____
6. Have you ever experienced or are currently experiencing any of the following? Yes No
 - Depression / feeling down / apathy
 - Bipolar disorder / extreme mood swings
 - Anxiety disorder / panic attacks (most recent occurrence): _____
 - Phobias (phobia triggers): _____
 - Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
 - Schizophrenia / hallucinations (auditory / visual)
 - Unexplained memory lapses
 - Alcohol / prescription medication / recreational drug abuse
 - Frequent body complaints (e.g., achiness, persistent pain, migraine / tension headaches)
 - Eating disorder (previous or current treatment): _____
 - Body image issues
 - Repetitive thoughts or behaviors (e.g., obsessions, rituals, etc.)
 - Problems with concentration, focus, learning disability
 - Trauma history / crisis
 - Homicidal thoughts / acts of aggression
 - Suicidal thoughts / attempts (last attempt / hospitalization): _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with any of the following? Yes No

- Depression
- Bipolar disorder / extreme mood swings
- Anxiety disorder / panic attacks
- Phobias (phobia triggers): _____
- Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
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- Problems with concentration, focus, learning disability
- Trauma history / crisis
- Homicidal thoughts / acts of aggression
- Suicide attempts / completion (family member): _____

Medical Problems

Active Problems / Health Concerns	Date of Onset

Surgical Procedures
(Last 10 Years Only)

Type of Surgery	Date of Surgery

Allergies

Drug / Food	Reaction

Current Medications Prescribed for Pain, Sleep Disturbance, Psychiatric Issues, Etc.

Medication	Dose	Start Date	Frequency	Reason for Taking	Prescribing Doctor

SECOND SPOUSE / PARTNER TO COMPLETE THIS SECTION SEPARATELY

Name: _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female Non-Binary

Ethnicity: Black White Asian Hispanic / Latinx Native American Other: _____

STUDENT / EMPLOYMENT STATUS:

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Length of Employment: _____ Retirement / Unemployment Date: _____

School and Grade or Major / Degree: _____

Employer Name and Position: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION:

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- Suicide attempts / completion (family member): _____

Medical Problems

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ONE OR BOTH PARTNERS CAN COMPLETE THE REMAINING PAGES

RELATIONSHIP STATUS:

Single Dating Partnered / Significant Other Married Separated Divorced Widowed

Duration of Relationship: _____ Number of Children: _____ Number of Children Still Residing in the Home: _____

Child's Name	Child's Age	Biological / Adopted / Step / Foster / Other?	Still Residing in the Home?	Who Has Primary Custody or Where Is Child Residing?
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

If married, has either of you threatened to separate or divorce as a result of the current relationship problems? Yes No

Have either you or your spouse consulted with a lawyer about divorce? Yes No

REASON FOR SEEKING COUPLES / MARRIAGE COUNSELING:

Please check any of the reasons listed below that resulted in your request for couples / marriage counseling:

- | | |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Pre-marital counseling | <input type="checkbox"/> Poor work-life balance / little time together |
| <input type="checkbox"/> Relationship enhancement | <input type="checkbox"/> Sexual orientation questions |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Alcohol / drug abuse |
| <input type="checkbox"/> Communication difficulties / arguments | <input type="checkbox"/> Sex addiction / pornography |
| <input type="checkbox"/> Physical intimacy issues / sexual relations | <input type="checkbox"/> Partner bullying / emotional abuse |
| <input type="checkbox"/> Parenting issues / parenting conflict | <input type="checkbox"/> Physical abuse / restraint / acts of aggression |
| <input type="checkbox"/> Partner values conflict | <input type="checkbox"/> Divorce threatened / possible separation |
| <input type="checkbox"/> Life transition / diminished health concerns | <input type="checkbox"/> Conflict with in-laws / partner's family |
| <input type="checkbox"/> Role conflict / responsibilities | <input type="checkbox"/> Other: _____ |

What would you like to gain from couples / marriage counseling? As a couple, what are your goals or specific issues you hope to address?

AUTHORIZATION OF PAYMENT OF SERVICES / INSURANCE INFORMATION

Credit Card Information and Authorization for Payment:

I, _____, authorize Katherine E. Walker, PhD, LCMHC, NCC to charge the below-referenced credit card when I have not cancelled my scheduled appointment within 24 hours or fail to show for my scheduled appointment time. I understand that this also includes any appointment that is considered a client no-show or for any balance due that is owed due to my insurance company not covering services.

Type of Card:

MASTERCARD

VISA

DISCOVER

AMERICAN EXPRESS

HSA CARD

Account Holder Name Listed on Credit Card: _____

Credit Card Number (Please Include Dashes): _____

Credit Card Expiration Date: _____

Credit Card Security Code (3-Digits on Back of Debit, MasterCard, or Visa; 4-Digit on Front of American Express):

Complete Billing Address for This Credit Card:

Authorized Card Holder Signature

Date

Insurance Information:

Insurance Carrier: _____

Plan Name: _____

Insured's Name: _____

Insured's ID Number: _____

Group ID Number: _____

Insured's Date of Birth: _____

Insured's Employer Name: _____

Insured's Address if Different from Client: _____

Please remember that I will be considered an out-of-network provider should you wish to use your insurance for reimbursement of payment for services. Let me know if you would like to submit claims to your insurance company and I will provide you with the information you will need to include on your member reimbursement claim.

Referral / Marketing Survey

To best help me accurately account for how clients initially find my professional services and to thank referral sources who directed you to me, please take a moment and check the box for which of the following best describes how you were initially referred to me. Additionally, please write in the name of the individual, medical or mental health practice name, or local business in the line provided if applicable.

- Referral by private health insurance such as supplemental health insurance provided by employer.
- Referral by employee assistance program, employee health, HR department, or supervisor / manager.
- Referral by a medical professional (include medical professional's name and practice name):

- Referral by another mental health professional (include mental health professional's name and practice name):

- Referral by someone who is seeing me or did see me for professional services (include individual's name):

- Posting of my business card or practice flyer in a local business (include name of business):

Online search engine listing or online general business directory listing:

- | | |
|------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Best of the Web | <input type="checkbox"/> Super Pages |
| <input type="checkbox"/> Bing | <input type="checkbox"/> Yahoo |
| <input type="checkbox"/> Google | <input type="checkbox"/> Yellow Book |
| <input type="checkbox"/> Manta | <input type="checkbox"/> Yelp |
| <input type="checkbox"/> Mapquest | <input type="checkbox"/> YP / Yellow Pages |

Online therapist directory listing:

- | | |
|---------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> All Therapist | <input type="checkbox"/> National Board for Certified Counselors |
| <input type="checkbox"/> Biofeedback Certification International Alliance | <input type="checkbox"/> Network Therapy |
| <input type="checkbox"/> Bio-Medical | <input type="checkbox"/> Psychology Today |
| <input type="checkbox"/> Good Therapy | <input type="checkbox"/> Sound Mindz |
| <input type="checkbox"/> LGBT Center of Raleigh | <input type="checkbox"/> Therapy Tribe |
| <input type="checkbox"/> Marriage Counseling Guide | <input type="checkbox"/> Theravive |

Social media website:

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Facebook | <input type="checkbox"/> YouTube |
| <input type="checkbox"/> LinkedIn | <input type="checkbox"/> Blogger |
| <input type="checkbox"/> Twitter | <input type="checkbox"/> Google+ |

Local print advertising:

- Official Guide to Wake Forest

~ Thank You! ~