Confidential Couples Counseling Intake Form

Please fill out this form to help us know more about you and to ensure your counseling sessions focus on what is most important to you. Information provided is confidential as outlined in the Professional Disclosure Statement. HIPPA Notice of Privacy is posted online at pillarsofhopecounseling.com. Happy to discuss any questions regarding either form.

Name_____Date_____

Name of Partner: _____

Address _____City/ State_____ Zip_____

Contact # _____Alternative # _____

OK to leave messages at these phone numbers? ☐ Yes ☐ No OK to text these numbers? ☐ Yes ☐ No
*Please note email and/or texting is not considered confidential communication.

Email _____ Partner's Email_____

Date & Place of Birth _____Age_____ Gender: ☐ F ☐ M

Partner's Date & Place of Birth _____Age_____ Gender: ☐ F ☐ M

Your current relationship status: ☐Married ☐Separated ☐Divorced ☐Dating ☐Cohabitating ☐Living together

Length of time in current relationship: _____

Are either of you currently attending school? ☐ Yes ☐ No Please check all degrees earned from the list below.

☐ High School Diploma or ☐ GED Year _____

☐ Associates Degree	Year _____	☐ Associates Degree	Year _____
☐ Undergraduate Degree	Year _____	☐ Undergraduate Degree	Year _____
☐ Master Degree	Year _____	☐ Master Degree	Year _____
☐ PhD Degree	Year _____	☐ PhD Degree	Year _____

Current Employer _____Position_____Length of Service _____

Current Employer _____Position_____Length of Service _____

Emergency contact person_____ Phone# _____

Referral source or how you came here: _____

List any health concerns _____

_____

_____

_____

List current medications:

Medication	Dosage	Start Date	Who

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Describe any past or present drug/ alcohol use/abuse or treatments. _____

_____

_____

Describe any suicide attempts or violent behavior._____

_____

_____

Have you or your partner received counseling before? ☐ Yes ☐ No (If "yes" please provide the reason and with whom) _____

_____

_____

What is the primary reason for seeking couples therapy? _____

_____

_____

What are or have you been doing to deal with your current relationship concerns? _____

_____

Describe your strengths as a couple. _____

_____

Please rate your current level of happiness with the relationship/marriage. **(1= extremely unhappy and 10= extremely happy).**

1 2 3 4 5 6 7 8 9 10

Please rate how stressful the relationship feels. **(1= extremely unhappy and 10= extremely happy).**

1 2 3 4 5 6 7 8 9 10

Please rate your current level of sexual satisfaction. **(1= extremely unhappy and 10= extremely happy).**

1 2 3 4 5 6 7 8 9 10

Has either partner threatened or begun divorce proceedings? ☐ Yes ☐ No If yes, who? _____

Have you received couples counseling or marriage therapy previously? ☐ Yes ☐ No If yes what was the outcome?

_____

_____

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Consent for Counseling Services Office Policies & General Information Agreement for Therapy Sessions

Name: _____

Name of Partner: _____

I request Angelie Karabatsos provide professional counseling, talk therapy, services for myself and/or my significant other.

I understand that Mental Health Services of Professional Counseling (talk therapy) is provided to me/us at a cost of $140.00-$200.00 per session.

I agree payment of services is due at the time of services, even if I am seeking reimbursement from my insurance company. I understand there is no guarantee of coverage or reimbursement for fees.

I understand it is my responsibility to contact my therapist 24-48 hours in advance, if I am unable to keep my appointment time to avoid paying full charges for missed appointments or no-show appointments.

I understand that my therapist will not be available for 24-hour crisis intervention or emergencies and I have been informed where to call if I have any emergency; Washington County Crisis Line (503) 291-9111, the National Suicide Prevention Line (800) 273-8255, or 911.

I acknowledge that I have received a copy of Angelie Karabatsos' Professional Disclosure Statement and have been directed to pillarsofhopecounseling.com for a copy of HIPPA Notice of Privacy Practices. I will review these documents and understand I may discuss questions with my therapist anytime during my treatment.

I understand that email, text, and social media are not confidential forms of communication. I give permission to be contacted by the following forms of communication: Phone ☐ Email ☐ Text ☐
I may request a change at any time by submitting a written request of change to Angelie Karabatsos.

Both partners must sign the Release Of Information in order for records to be released.

I understand too many late cancels and/or non-payment for late cancel/no show appointment may result in termination.

If there has been no appointments within 90-days the relationship will be terminated. Clients may resume counseling at anytime.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above with the understanding that my therapist and I will clarify goals and objectives at any time.

X_____ _____
Signature of Client Date

X_____ _____
Signature of Client Date