Confidential Family Counseling Intake Forms

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, the counseling office policies, and HIPPA Notice of Privacy posted online at pillarsofhopecounseling.com. We would be happy to discuss those with you.

Name of Primary Contact_____Date_____

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_____

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

Please fill out the below table for all parties attending counseling.

Adult 1 Name: **Gender:** ☐ F ☐ M **Date of Birth:** **Age:** **Education:** **Occupation:** **Employer:**	**Adult 2 Name:** **Gender:** ☐ F ☐ M **Date of Birth:** **Age:** **Education:** **Occupation:** **Employer:**	**Adult 3 Name:** **Gender:** ☐ F ☐ M **Date of Birth:** **Age:** **Education:** **Occupation:** **Employer:**
Adolescent: **Gender:** ☐ F ☐ M **Date of Birth:** **Age:** **Education:**	**Adolescent:** **Gender:** ☐ F ☐ M **Date of Birth Place:** **Age:** **Education:**	**Adolescent:** **Gender: F M** **Date of Birth:** **Age:** **Education:**

Emergency contact person_____ Relationship _____

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._____

_____

_____

Has anyone received counseling before? ☐ Yes ☐ No (If "yes" please provide the reason and with whom) _____

_____

What is the primary reason for seeking family counseling?

_____

_____

_____

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

_____

Describe your strengths as a family. _____

_____

Is there any history of CPS/Department of Child and Family Services involvement, including abuse/neglect reports, investigations, or removal of children from home? ☐ Yes ☐ No

Have any of your children ever lived in another family situation (e.g., foster family, other caregivers, grandparent or kinship care, group home or residential placement)? ☐ Yes ☐ No

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

Name: _____

I request Angelie Karabatsos provide professional counseling, talk therapy, services for myself and family.

I understand that Mental Health Services of Professional Counseling (talk therapy) is provided to me/us at a cost of $175.00-$250.00 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.

All parties 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

X_____ _____
Signature of Client Date

X_____ _____
Signature of Client Date