Client Intake Form

Barnwell Counseling & Family Therapy, PLLC

Today's Date: ___________________________

Name ____ Phone (_____)___________________________

Address ____ City/State/Zip _____________________________________

DOB _____________________ Age _____________________ Sex ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Occupation ____ Employer ____________________________________

Primary Care Physician ________________________________ Referred By __________________________________

Emergency Contact ____ Phone (_____)_________________________

Have you received counseling services in the past? ❑ YES ❑ NO

If yes, counselor's name(s) ____

If yes, for what issues ____

Please take a moment to carefully read the following information and initial where indicated. I consent for Michelle Barnwell, LCSW to communicate with me by email and/or my telephone (text messaging) at the following email address and telephone number. I will immediately notify Michelle Barnwell, LCSW in the event of a change.

Initial__________ Email Address: ____

Initial__________ Phone Number: (_______)____

What are your primary concerns and/or symptoms:

- ❑ **Aggression**
- ❑ **Alcohol Dependence**
- ❑ **Antisocial Behavior**
- ❑ **Anxiety**
- ❑ **Avoiding People**
- ❑ **Chest Pain**
- ❑ **Depression**
- ❑ **Disorientation**
- ❑ **Distractibility**
- ❑ **Mood Shifts**
- ❑ **Worrying**
- ❑ **Elevated Mood**
- ❑ **Eating Disorders**
- ❑ **Fatigue**
- ❑ **Hopelessness**
- ❑ **Judgment Errors**
- ❑ **Memory Impairment**
- ❑ **Phobias/Fears**
- ❑ **Sick Often**
- ❑ **Sleeping Problems**
- ❑ **Suicidal Thoughts**
- ❑ **Trembling**
- ❑ **Dizziness**
- ❑ **Addiction**
- ❑ **Recurring Thoughts**
- ❑ **Hallucinations**
- ❑ **Impulsivity**
- ❑ **Loneliness**
- ❑ **Drug Dependence**
- ❑ **Sexual Difficulties**
- ❑ **Speech Problems**
- ❑ **Disorganized Thoughts**
- ❑ **Withdrawing**
- ❑ **Panic Attacks**
- ❑ **Relationship Issues**
- ❑ **Other, Please Specify** ____

I hereby consent to treatment provided by Michelle Barnwell, LCSW. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible for any balance due prior to discontinuing therapy.

Client Signature ____ Date ___________________________

Therapist Signature____ Date___________________________

Consent to Treatment of Minor: By my/our signature(s) below, I/we hereby grant full and unconditional authority to Michelle Barnwell, LCSW to proceed with a clinical evaluation and treatment of a minor child ____. By granting this consent, I am affirming that I have legal power to consent to medical, psychological, and mental health assessment of said minor child.

Signature of Mother or Guardian: ____ Date: ________________

Signature of Father or Guardian: ____ Date: ________________

Informed Consent for Counseling Services

Michelle Barnwell, LCSW would like to thank you for choosing Barnwell Counseling & Family Therapy, PLLC for your counseling needs. Counseling services are provided to adolescents, adults, families, couples, and groups who are seeking assistance in solving life's problems and the difficulties that sometimes arise in relationships. Michelle Barnwell is a skilled and experienced licensed clinical social worker. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. If at any time you feel that the relationship between you and Michelle Barnwell, LCSW is not a good fit, please discuss this matter to determine if transferring to a more suitable therapist is right for you.

Michelle Barnwell, LCSW provides counseling services designed to address many of the issues that leave clients struggling. However, as with any treatment, there are inherent risks. Counseling can sometimes generate emotions such as depression, anxiety, anger, guilt, and sadness. Counseling may also alter your view of relationships and important people in your life. It is important for these feelings to be processed in our counseling sessions. While there is no guarantee that your treatment goals will be met, your therapist is a skilled professional, dedicated in assisting you to achieve your stated goals. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, exploring approaches, and developing solutions), and an ending (evaluation of goal attainment, after care goals, closure, and termination activities). To attain the best results, it is Michelle Barnwell's hopes that you will see your therapeutic process through all phases.

Below is an outline of the policies and procedures used in our practice, we ask that you review and sign where indicated. Michelle Barnwell, LCSW will be available to you to discuss these policies and procedures with you in order to make an informed decision about whether to proceed with counseling services. ***Initials**__________

Initial Counseling Session:

Your first visit will be an assessment in which you and your therapist will discuss your concerns, review your personal and family history, and determine if you are good match for therapy. Treatment goals, schedule availability, confidentiality, and fees for services will be discussed and should be agreed upon. The goal of Michelle Barnwell, LCSW is to provide the most effective therapeutic experience available to you. If you and Michelle Barnwell, LCSW decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. ***Initials**__________

The Client/Therapist Relationship:

Appointments are typically scheduled on a weekly basis and are 50-minutes in duration. More frequent sessions or an intensive outpatient schedule is available if determined appropriate by your therapist.

You will be considered an active client of this practice if you keep each appointment or make alternative appointments in this office. After the passage of 45 days without contact between you and your therapist, you will be considered an inactive client. Termination of the counseling relationship may begin after 2 missed appointments without calling to cancel or rescheduling your appointment. Additionally, any balance on the account for missed appointments must be paid prior to rescheduling an appointment.

You and Michelle Barnwell have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Michelle Barnwell can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. The National Association of Social Workers (NASW) Code of Ethics prohibits dual relationships between the clinician and the client. This means as a client, Michelle Barnwell cannot meet with you on social occasions or be involved in any business activities with you other than providing psychotherapeutic services. Gifts are not appropriate, nor are any sort of trade of

service for service. Barnwell Counseling & Family Therapy, PLLC strives to avoid dual relationships and conflicts of interest, which can negatively influence the therapeutic relationship with a client. If a family member of a current client verbalizes the need for counseling services, Michelle Barnwell will attempt to suggest other resources or referrals for assistance. ***Initials__________**

Confidentiality:

Barnwell Counseling & Family Therapy, PLLC follows all ethical standards prescribed by state and federal law. Barnwell Counseling & Family Therapy, PLLC is required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Please be advised that there are certain situations in which it is required by law to reveal information obtained during therapy to the other person or agencies without our permission These limits to confidentiality in the state of Texas include but are not limited to the following situations:

- Threatening harm or death to yourself (suicide)
- Threatening harm or death to another person (homicide)
- Abuse to a child or the elderly or disabled
- Abuse of patients in a mental health facility
- Sexual exploitation
- HIV/AIDS infection and possible transmission
- If a court of law issues a subpoena for notes/records
- If the therapy and/or evaluation is court ordered
- If you are seeking payment through an insurance company (client/guardian is responsible for filing own claim)

***Initials__________**

Emergencies:

You may encounter a personal emergency requiring prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your call will be returned as soon as possible but cannot be guaranteed until the next business day. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. ***Initials__________**

Communication:

Communication is a necessary and vital part of your relationship with your therapist. However, it is important to understand the constraints that exist related to different types of communication. As noted earlier in the "Confidentiality" section of this document, all efforts will be made to ensure confidentiality of each session, within constraint of Texas laws. However, please review the following sections on Telephone and Electronic Communication closely.

Telephone Communication: When available Michelle Barnwell will respond by cell phone between sessions and at the beginning and end of each business day. If you find yourself facing an emergency situation, please contact emergency services (911) immediately and/or go to your nearest hospital emergency room. Emergency counseling services are available by telephone. **Telephone calls lasting longer than 10 minutes in length will be billed at my hourly rate, with a minimum of 15-minute increments.** Non-Emergency calls after 5:00pm may not be returned until the next business day. ***Initials__________**

Electronic Communication: Text messaging is available. Please feel free to contact your therapist via text message at (214) 663-8482. This form of communication cannot ensure confidentiality and should be reserved for mere scheduling and/or canceling appointments.

When available, Michelle Barnwell will respond by email communication, as appropriate. Barnwell Counseling & Family Therapy, PLLC cannot ensure confidentiality of any correspondence sent via email and cannot be responsible for breaches in confidentiality resulting from someone getting our password or having access to your email account. Therefore, email communication should be reserved for appointment cancellation or rescheduling. If the content of your email contains more than scheduling information, your therapist will contact you by telephone to discuss your concerns further. Additionally, all email correspondence between you and your therapist will be placed in your file and become part of your chart. Michelle Barnwell, LCSW will attempt to respond to your email electronically or by telephone within 24 hours or one business day depending on the content. ***Initials__________**

Social Media: Social media is a fantastic tool to help people become informed and engaged. Michelle Barnwell, LCSW uses social media for Barnwell Counseling & Family Therapy, PLLC. In an effort to be completely transparent, this social media policy has been created to assist in your understanding of how social media is used as a part of the practice and how it could impact our relationship. The basis of the policy is to protect our relationship and your confidentiality.

- **Friending:** To respect your privacy and confidentiality, Michelle Barnwell, LCSW does not accept friend requests from current or former clients on any social networking site. As a therapist, the relationship with you is kept completely confidential with the exception of threats to harm yourself or others. Thus, if you post on our personal or business page, you are opening up the possibility of people inferring about our relationship or asking about our connection. You get to decide what you tell people. You have a choice as to what you reveal about yourself online, however we will not reveal our connection to you.
- **Fanning:** You may "like" the Barnwell Counseling & Family Therapy Facebook business page. If you "like" this page, you are choosing to reveal that you are connected to us in some way. Our business page exists to be a forum of information and inspiration. Michelle Barnwell, LCSW will not engage in conversations with you on that page. However, if you find it helpful then that is great!
- **Interacting:** Please do not use messaging on Social Networking sites such as Facebook or LinkedIn to contact Michelle Barnwell, LCSW. Also, in the event of an emergency, the response would likely not come in a timely manner as these accounts are not checked on a daily basis. The best way to interact is by email or phone. If you post on our sites, it may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived.

***Initials__________**

Insurance Policy and Payment:

Barnwell Counseling & Family Therapy, PLLC operates as an out-of network provider giving clients all the necessary paperwork to file their own insurance reimbursements. Michelle Barnwell, LCSW will cooperate fully by providing any information requested by your insurance company directly to you for you to share with your insurance company at your discretion. Please be advised that your insurance company may limit the number of sessions you have available or deny the coverage for services you are seeking. Therefore, Barnwell Counseling & Family Therapy, PLLC advises you to verify your benefits before your first appointment.

Payment of fees are required at the end of each counseling session. Clients are responsible for all payments and fees. Payments can be made with a check, cash, or credit card. A detailed receipt will be provided to you at the end of each session documenting the services delivered and the fees paid. This receipt will have all information typically requested by insurance companies for reimbursements. ***Initials__________**

Schedule of Fees:

Service	Description	Duration	Fee
Diagnostic & Evaluation Session- Individual or Couples	1st Session	50 Minutes	$125
Diagnostic Evaluation Session- Family	1st Session	90 Minutes	$150
Regular Office Visits (Individuals & Couples)		50 Minutes	$125
Regular Office Visits (Family Sessions)		90 Minutes	$150
Extended Session		15 Minute Intervals	$35
Group Therapy		TBD	Varies
Emergency Weekend Session	Crisis Counseling	50 Minutes	$125
Counseling Services Provided by Telephone		15 Minute Intervals	$30
Written Reports (Insurance Companies, Supervisors, Schools)		Pro-rated	$125
Late Cancellation & Missed Appointments			$125- $150
Returned Check Fee per Check			$45

***Initials___________**

Additional Fees:

Cancellation Policy: If you fail to come to your appointment or you give less than a 24-hour notice, you will be charged a late cancellation or missed appointments fee at the full session rate of $125 for individuals & couples or $150 for families. This is necessary because a time commitment is made to you and is held exclusively for you. ***Initials___________**

Court Fees: If a deposition or an opinion in court is required, there is a $500 per hour charge. The minimum charge is $1500 paid in advance. Payment is due three business days in advance of the legal proceeding or court appearance. The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/clerk for preparation.
***Initials___________**

Medical Records: A copy of your medical records can be provided to you for a fee of $30 for the first twenty pages and $.75 per page for every copy thereafter. In addition, a reasonable fee may include the actual cost for mailing, shipping, or delivery. ***Initials___________**

Discontinuing Treatment:

I understand that I am free to discontinue treatment at any time and that I agree to notify Michelle Barnwell, LCSW immediately so that I may be provided with referrals for continued care. Additionally, Michelle Barnwell, LCSW has the right to terminate your treatment at any time. Termination of treatment may be due to the following: boundary violations, non-compliance with treatment, failing to follow appointment policies/procedures, non-payment of fees/services rendered. If your therapist decides to terminate services, you will be provided with written notification and a referral for another therapist or agency, if requested. ***Initials____________**

Incapacity or Death:

I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing. ***Initials____________**

Health Insurance Portability and Accountability Act (HIPAA):

Federal Law, HIPAA, requires privacy protection for medical records and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires we provide you with a Notice of Privacy Practices. The Notice of Privacy Practices, which is contained within this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information at the end of this session (Notice of Privacy Practices/HIPAA Receipt). ***Initials_____________**

Consent for Treatment

By signing this Client General Policies and Consent Form as the Client or Guardian of the said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment, and services for myself (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of the said child, or impacting your rights with respect to the child's mental health care and treatment, Barnwell Counseling & Family Therapy, PLLC will not render services to your child until a copy of the most recent copy of the court order has been received and reviewed by a therapist.

____

Name of Client (Please Print)

____ ______________________

Signature- Client/Parent Date

____ ______________________

Signature- Spouse/Partner/Parent Date

____ ______________________

Signature of Therapist Date

NOTICE OF PRIVACY PRACTICES/HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment.

Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment.

We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations.

We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law.

Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect
Emergencies
National Security
Judicial and Administrative Proceedings
Law Enforcement
Public Safety (Duty to Warn)

Without Authorization.

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission.

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization.

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Michelle Barnwell at Barnwell Counseling & Family Therapy, PLLC:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Michelle Barnwell at Barnwell Counseling & Family Therapy, PLLC or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is November 16, 2015.

Receipt and Acknowledgement of Privacy Practices/HIPAA

Printed Name:____ **DOB:** __________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Barnwell Counseling & Family Therapy Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Michelle Barnwell, LCSW

Signature of Patient/Client ____ Date ____________________

Signature of Parent, Guardian or Personal Representative*______________________________ Date _______________

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**

Signature of Therapist ____ Date_____________________

Couples Intake Form

Please fill out all information on this form as fully or openly as possible and bring it to your first appointment. All information is held in strictest confidence. If certain questions do not apply, please indicate in the space provided.

Name____ Date of 1st Appointment __________________

Date of Birth____________________ Age ______________ Gender: ❑ Male ❑ Female

What are the problem(s) for which you are seeking help?

1.____

2. ____

3.____

What are your treatment goals?

____

____

Marital Status:
- ❑ Single, Never Married
- ❑ Engaged ___ months
- ❑ Married for ___years
- ❑ Divorced for ___years
- ❑ Separated for ___years
- ❑ Divorce in progress
- ❑ Co-habituating for ___ months/years
- ❑ ____ prior marriages (self)
- ❑ ____ prior marriages (partner)

Relationship Satisfaction:
- ❑ Very satisfied with my relationship
- ❑ Satisfied with my relationship
- ❑ Somewhat satisfied with my relationship
- ❑ Dissatisfied with my relationship
- ❑ Very dissatisfied with my relationship

Concern with Relationship Issues:
- ❑ No Concern
- ❑ Little Concern
- ❑ Moderate Concern
- ❑ Serious Concern
- ❑ Very Concerned

About Your Concerns (Circle all that apply- S=Self P=Partner B= Both):

Concern		Concern		Concern		Concern	
Abuse-Emotional	S P B	Abuse-Neglect	S P B	Abuse- Physical	S P B	Anger	S P B
Abuse- Sexual	S P B	Addiction- Pornography	S P B	Addiction (Prescription)	S P B	Aggression	S P B
Addiction (Over-the Counter)	S P B	Addiction (Street Drugs)	S P B	Anxiety	S P B	Excessive Arguing	S P B
Lack of Affection	S P B	Communication	S P B	Childhood Issues	S P B	Crying	S P B
Children-Daily Care	S P B	Children-Custody	S P B	Children- management	S P B	Concern with Previous Relationship	S P B
Codependence	S P B	Career Concerns	S P B	Housework Sharing	S P B	Lack of Physical Intimacy	S P B
Compulsive Spending	S P B	Compulsions	S P B	Dependence on Partner	S P B	Inability to make decisions	S P B
Death in the Family	S P B	Depression	S P B	Debt	S P B	Delusions (false ideas)	S P B
Lack of Love	S P B	Lack of Emotional Intimacy	S P B	Fear of losing the relationship	S P B	Domestic Violence	S P B
Emptiness	S P B	Guilt	S P B	Financial Trouble	S P B	Excessive Drinking	S P B
Chronic Fatigue	S P B	Feeling like a failure	S P B	Grieving	S P B	Easy to lose control	S P B
Gambling Addiction	S P B	Goals not being met	S P B	Impulsive Spending	S P B	Friendships affecting your relationship	S P B
Post-Partum Depression	S P B	Hostility	S P B	Irritability	S P B	Health Issues	S P B
Indecision	S P B	Inhibitions	S P B	Laziness	S P B	Impulsiveness	S P B
Irresponsibility	S P B	Judgment Problems	S P B	Loss	S P B	Interpersonal Conflicts	S P B
Loneliness	S P B	Loss of Control	S P B	Marital Issues	S P B	Legal Issues	S P B
Low Frustration Tolerance	S P B	Low Income	S P B	Motivation	S P B	Low Energy	S P B
Mixed Feelings	S P B	Mood Swings	S P B	Overwhelmed	S P B		

Obsessions	S P B	Outburst	S P B	Overwhelmed	S P B	Mourning	S P B
Oversensitive to Rejection	S P B	Panic or Anxiety Attacks	S P B	Perfectionism	S P B	Affair(s)	S P B
Physical Problems	S P B	Procrastination	S P B	Sadness	S P B	Oversensitive to Criticism	S P B
Poor Self-Care	S P B	Relationship Problems	S P B	Relaxation (Difficulty)	S P B	Pessimism	S P B
Risk-Taking Behavior	S P B	Lack of Time Together	S P B	Self-Harm-Cutting	S P B	Phobias	S P B
Shyness	S P B	Self-Esteem	S P B	Self-Neglect	S P B	Trust Issues	S P B
Sexual Dysfunctions	S P B	Sleep-Insomnia	S P B	Sleep-Nightmares	S P B	Religious Concerns	S P B
Sleep-too much	S P B	Issues related to Step-		Stress	S P B	Self-Centeredness	S P B
Suicidal Thoughts	S P B	Parenting	S P B	Trust Issues	S P B	Sleep-too little	S P B
Self-Control	S P B	Temper Problems	S P B	Thought Disorganization	S P B	Stress Management	S P B
Tobacco Use	S P B	Tension/Stress	S P B	Work Problems	S P B	Suspiciousness	S P B
Withdrawal	S P B	Violence	S P B	Social Isolation	S P B	Shame	S P B
Hopelessness	S P B	Worthlessness	S P B	Trauma- Sexual	S P B	Weight & Diet Issues	S P B
Trauma-Physical	S P B	Agitation	S P B	Lack of Respect	S P B	Employment Issues	S P B
Trauma- Emotional	S P B	Worry	S P B	Sexual Fulfillment	S P B		

Other____

____

About Your Household:

Please take a moment to list all individuals living in your current household. On the lines following, list immediate family members or close family friends (those you may consider as family) who provide you with ongoing support.

Household Member	Age	Relationship
Immediate Family not living in Household	**Age**	**Relationship**

Describe any past or current significant issues in other immediate family relationships (excluding the relationship with your partner):

____

____

____

About Your Relationship with your Partner:

Describe any past or current significant issues in your marriage or intimate relationships:

____

____

____

Have you or your partner threatened to separate or divorce (if married) as a result of the current relationship problems? ❑ **Yes** ❑ **No** **If so, who?** ________________________

Have you or your partner consulted with a lawyer about divorce?
❑ **No** ❑ **Yes (Self)** ❑ **Yes (Partner)** ❑ **Yes (Both)**

Do you perceive you or your partner withdrawing from the relationship?
❑ **No** ❑ **Yes (Self)** ❑ **Yes (Partner)** ❑ **Yes (Both)**

How frequently have you had sexual relations in the past month? ______________

How enjoyable is your sexual relationship? (Circle One)
(extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle One)
(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What is your current level of stress in the relationship? (Circle One)
(no stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

Please list current hobbies or personal interests that interfere with your relationship:

____

Please list current hobbies or personal interest you share with your partner:

____

Medical/Emotional/Psychiatric History

Please list any medication you are currently taking:

Medication	Dosage	Treatment of Symptoms	Length of Medication Use

Describe current state of physical health: ❑ **Good** ❑ **Fair** ❑ **Poor**
Please explain if needed:
____

Is there a history of any of the following in your immediate family?

- ❑ Tuberculosis
- ❑ Thyroid Problems
- ❑ Alzheimer's disease/Dementia
- ❑ Anorexia
- ❑ Heart disease
- ❑ Cancer
- ❑ Stroke
- ❑ Chronic Health Issues
- ❑ Birth defects
- ❑ Mental Retardation
- ❑ Miscarriage
- ❑ Terminal Illness
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Obesity
- ❑ Other____

Family Psychiatric History:

- ❑ Bipolar
- ❑ Anxiety
- ❑ Personality Disorders
- ❑ Schizophrenia
- ❑ Suicide
- ❑ Depression
- ❑ Oppositional Defiance
- ❑ Post-traumatic Stress
- ❑ Violence
- ❑ Other____

If yes, who had each diagnosis/problem____

____

Please list any previous medical or psychiatric hospitalizations:

Date_________ Age_______ Reason ________________________ Length of stay _____________
Date________ Age______ Reason________________________ Length of stay _____________
Date________ Age______ Reason________________________ Length of stay _____________
Date________ Age______ Reason________________________ Length of stay _____________

Please list the name of your Primary Care Physician____
Psychiatrist (if any) ____
Previous Counseling Experience (for yourself or household members):
Counselor: ____ Treatment Dates (or duration) ______________________
Counselor: ____ Treatment Dates (or duration) ______________________
Counselor: ____ Treatment Dates (or duration) ______________________

Substance Abuse Status:

- ❑ No history of abuse
- ❑ Active Abuse
- ❑ Early Full Recovery
- ❑ Early Partial Recovery
- ❑ Sustained Full Recovery
- ❑ Sustained Partial Recovery

Family Alcohol/Drug Abuse History:

- ❑ Father
- ❑ Mother
- ❑ Sibling(s)
- ❑ Grandparents
- ❑ Other____

Substances Used (please check all that apply):

Substance	Current Use	Frequency	Amount
❑ Alcohol	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Amphetamines	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Barbiturates	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Caffeine	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Cocaine	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Crack Cocaine	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Hallucinogens	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Inhalants (e.g. glues, gas, etc.)	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Marijuana	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Nicotine	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ PCP	**Current Use: Yes or No**	Frequency__________________	Amount__________________
❑ Prescription	**Current Use: Yes or No**	Frequency__________________	Amount__________________

❑ Other____

CREDIT CARD AUTHORIZATION

I hereby grant to Michelle Barnwell, LCSW – Barnwell Counseling & Family Therapy, PLLC permission to process credit/debit charges.

The security of your personal information is extremely important. Michelle Barnwell, LCSW – Barnwell Counseling & Family Therapy, PLLC is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the "information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

This form is requested for all clients and required to be on file.

Client Name/s: ____

Please read all below:

Acceptable forms of payment are cash, check, debit card or credit card.

My initials below:

_________ Without my debit/credit card, I authorize Michelle Barnwell, LCSW – Barnwell Counseling & Family Therapy, PLLC to use my credit/debit card number provided below to process charges/fees assigned to any named individual(s) listed above.

_________ I authorize Michelle Barnwell, LCSW – Barnwell Counseling & Family Therapy, PLLC to be compensated for missed appointments of which the client/s named above did not show up for session or canceled session less than 24 hours before the time of the appointment. Late Cancellations and missed appointments are billed at the rates listed in the fee schedule.

Please complete all of the information below:

Type of Card (circle): American Express Visa MasterCard

Exact Name on Card: ____

Relationship to Client: ____

Card Number: ____

Expiration Date: ____

3-4 Digit Security Code/CVC: ____

Billing Address: ____

Email Address: ____(for electronic receipts)

Signature: ____ Date: ___________________