Confidential Intake Packet

Client's Legal Name _____ Date _____

Address_____

City _____ State _____ Zip _____

Phone number(s):
Home (_____)_____ Ok to leave a message? YES NO

Cell (_____)_____ Ok to leave a message? YES NO

Would you like a text reminder for upcoming appointments? Y / N

Email _____ Ok to contact via email? Y / N

Would you like an email reminder for upcoming appointments? Y / N

How & where did you hear about us?

Google Insurance FaceBook Church/Pastor Friend/Family Theravive

Psychology Today GoodTherapy TherapyNetwork Other_____

Date of Birth _____ Social Security Number _____

How do you identify your gender? _____

How do you identify your ethnicity (race)? _____

Marital Status (Please Circle):

Married Single Widowed Divorced Separated Engaged

Common Law Living Together Partners/Committed Other

Religious preference: His/Hers_____ His/Hers_____

If so, where do you attend?_____

Occupation: His/Hers_____His/Hers_____

Employer: His/Hers_____His/Hers_____

Please briefly describe your reason for coming to Refresh Therapy

_____

_____

_____

Have you been in therapy before? Y / N

Are you currently receiving therapy elsewhere? Y / N

If yes, with whom and for how long? _____

If applicable, briefly tell us your impressions of past therapy services

_____

_____

If your therapist deems it helpful and/or necessary, do you give Refresh Therapy Inc, permission to contact your physician in order to coordinate services? Y / N

If yes, what clinic/doctor? _____

Please list current medications

_____

_____

List any health problems for which you currently receive treatment

_____

_____

List any past health problems that have impacted your life

_____

_____

Have you ever been hospitalized for a psychiatric illness? Y / N

Does anyone in your immediate family have mental health issues? Y / N

If yes, please describe _____

Have you ever seriously considered suicide? Y / N

If yes, when? _____

Have you ever attempted suicide? Y / N

If yes, when? _____

Have you ever dealt with drug and/or alcohol addiction? Y / N

If yes, please describe _____

Marital History

1st Marriage: Date began _____ Ended? Y / N If yes, When? _____

Name of spouse _____ Children & ages _____

2nd Marriage: Date began _____ Ended? Y / N If yes, When? _____

Name of spouse _____ Children & ages _____

3rd Marriage: Date began _____ Ended? Y / N If yes, When? _____

Name of spouse _____ Children & ages _____

If currently in a committed relationship, briefly describe the state of that relationship

_____

_____

Partner's Name _____ Occupation _____

How long have you been together? _____

Children (include biological, step, foster, adopted, etc.)

Name Sex Age Type (bio, step etc) Lives with

_____

_____

_____

_____

Who are significant people and/or family members in your life?

_____

_____

Are you, or anyone in your family, currently or recently involved with:

Department of Human Services (CPS) Y / N Who? _____
Department of Corrections Y / N Who? _____
Probation or Parole Y / N Who? _____
Addiction treatment/rehabilitation Y / N Who? _____
Other _____

Please circle any of the following which are currently causing you difficulty. Please feel free add your own in the space provided.

Siblings	Health Problems	Self worth	Communication
Parents	Trouble sleeping	Sexual Problems	Concentration
In Laws	Nightmares	Health	Abuse
Parenting	Excessive worry	Energy	Finances
Children	Depression	Anger	Decision Making
Friends	Motivation	Disordered eating	Grief
Gender identity	Mood Swings	Stress	Weight Issues
Sexual Orientation	Panic Attacks	Substance Use	Phobias/Fears
Infertility	Self Harm/Cutting	Alcohol Use	My Past
Adoption	Life Transitions	Work/School	Trust Issues
Pregnancy loss	Suicidal thoughts	Divorce/Separation	
Childbirth complications	Spirituality	Unhappiness	

Please * the top 3 that are causing you the most difficulty

Please list any other concerns or symptoms you would like your therapist to know about

_____

_____

Please provide any additional information you feel may be useful for your therapists to know

_____

_____

If applicable, for clients under 18, please complete this section:

1) Parent/Guardian's name: _____

Parent/Guardian's address: _____

Parent/Guardian's phone #: _____

2) Parent/Guardian's name: _____

Parent/Guardian's address: _____

Parent/Guardian's phone #: _____

School Attended: _____

Please provide a brief summary of pertinent academic performance

and/or behaviors in school _____

_____

Suspended from school? Y / N

Involvement with juvenile probation? Y / N

Concerns about substance use? Y / N

Credit Card Authorization Form

I, _____, authorize Refresh Therapy Inc., to charge my credit card for professional services as follows:

- I understand, and agree, that my card will be charged Refresh Therapy's full session rate of $130.00/50 minutes or $190.00/80 minutes for cancellations with less than 24 business hours notice and/or for appointments missed without notice, as agreed to in the Client Consent and Disclosure Form.
- I understand and agree that my card will be charged for balances of charges not paid by me.
- I understand this form is valid until my card's expiration or if my card account number changes, unless I cancel the authorization in writing.
- I will not dispute charges for sessions I have received, cancellations, or appointments I missed according to the aforementioned policies.

Cardholder Name: _____

Billing Address: _____

Credit Card Type (circle one): Visa MasterCard Discover Amex

Credit Card Number: _____

Expiration Date: _____

Card Security Code (last 3 digits located on the back of the credit card): _____

Print Name, Sign and Date Below:

Name: _____ Date: _____

Signature: _____