MARTI WIBBELS, M.S., L.M.H.C., P.A.
PALM BEACH COUNSELING

INTAKE FORM

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	Gender: M / F
# of Dependents:	
Home Phone:	Is it OK to leave a message for you at this number? Y / N
Work Phone:	Is it OK to leave a message for you at this number? Y / N
Mobile Phone:	Is it OK to leave a message for you at this number? Y / N
Mailing Address:	
E-mail address:	Is it OK to email you? Y / N
Names of others living at home with you:	
Current Occupational Status: (i.e., F/T, P/T, self-employed, unemployed, student, returning to work):	
Employer:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred? (If online, which website?)	

Current Concerns:

What is your main reason for seeking counseling? _____

_____

_____

When did this concern begin (give dates)? _____

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern: _____

_____

_____

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties. _____

_____

_____

What do you hope to accomplish in counseling? _____

_____

_____

What kind of obstacles could get in the way? _____

_____

_____

Have you been in therapy before or received any prior professional assistance for your concerns? Y / N

_____

_____

_____

If so, please give dates of treatments and results: _____

_____

_____

_____

Behavioral– circle any of the following behaviors that apply to you:

Overeating	Suicidal attempts	Can't keep a job	Taking drugs	Compulsions
Insomnia	Vomiting	Smoking	Taking too many risks	Odd behavior
Withdrawal	Lack of motivation	Drinking too much	Nervous tics	Eating problems
Working too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change? _____

_____

_____

_____

_____

Emotional – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Bitter	Others:

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Spiritual Factors:

Religious background_____ Present affiliation, if any _____

Is this an important part of your life?_____Do you have any current concerns in this area? Y / N

If so, please describe: _____

_____

_____

Biological Factors:

Do you have any current concerns about your physical health? Please specify: _____

_____

_____

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Have you had any surgery in the past three years? If so, please specify: _____

_____

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter): _____

_____

_____

Do you get regular exercise? Y / N If so, what type and how often? _____

_____

_____

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Are there any other mental, emotional or spiritual concerns you want to address in therapy? _____

_____

_____

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THERAPY AGREEMENT

I, _____, have applied for counseling and/or assessment services at Marti Wibbels, M.S., L.M.H.C., P.A. (Palm Beach Counseling) for myself and the following person(s) for whom I am legally responsible.

_____ _____

_____ _____

I understand that, due to confidentiality, counseling sessions may not be recorded in any form.

I am responsible for any indebtedness incurred as a result of services rendered to me or those under my guardianship by this therapy or assessments.

I understand that if, during the course of treatment, the counselor determines that a threat of physical harm (including child or elder abuse) to the client or to another person is imminent, by law, the appropriate authorities must be notified, in accordance with the following Florida Statutes: (FS 39.201; FS 39.202; FS 39.204; FS 490.0147; FS 491.0147).

I further agree to indemnify and hold harmless Marti Wibbels, Palm Beach Counseling, its agents, volunteers or employees from any claim for damages of any nature arising out of or allegedly due to any counseling, instruction or advice rendered by personnel of Palm Beach Counseling, or out of any activity related thereto. I accept full responsibility for any decisions I make regarding my life.

I have read the above information carefully, understand its contents, and agree, under these conditions, to receive services for myself and/or anyone herein designated.

_____ _____

Signature Date

_____ _____

Signature

PAYMENT AGREEMENT

Client Responsibilities

Payment is due at the time service is rendered. Please pay by cash, check or credit card. If paying by check, please make check payable to Marti Wibbels.

The fee is $125.00 for a 45 to 50-minute session, or $187.50 for a 75-minute session.

Sessions of three (3) or more people are billed at the rate of $250 for a 45 to 50 minute session.

Cancellation of a session must be made at least 24 hours prior to the scheduled time or you will be billed for the missed session.

For reasons of confidentiality, we do not make appointment reminder calls. You are responsible for keeping your appointments.

An invoice may be sent to your home for any outstanding balance.

The undersigned certifies that he/she has read the above information carefully, understands its contents, and agrees to comply with the terms of payment as provided above.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

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CREDIT CARD AUTHORIZATION FORM

Date:_____

This is to authorize payment for _____ for counseling sessions at the rate of $_____ per 50-minute session. I understand that my credit card will be charged on the day of my scheduled appointment, prior to the session in order to maximize my scheduled time. I authorize _____(number) of sessions to be charged with this card.

Please initial the following:

_____ I understand that appointments require a 24-hour cancellation notice. Because my appointment time is set aside exclusively for me, I understand that no-show appointments will be charged in full if the appointment is not cancelled or rescheduled at least 24-hours prior to the appointment.

_____ If credit card on file is not approved for payment, I understand that alternate payment arrangements must be made within 5 business days after I am notified of a declined credit card payment.

Credit Card Type: [ ] VISA [] MC [ ] AMEX [] DISC

Credit Card Number:

CCV: | | **Exp date:** | | | / | | |

Cardholder's name as it appears on the credit card:

Cardholder's billing address:

Street:		
City:	State:	Zip Code:

Cardholder's phone number: _____

Cardholder's Signature: _____