Martin Counseling, PLLC

We are honored by your decision to seek assistance from our Counseling Services. Your response to this form will serve as a brief and helpful introduction. All submitted information is confidential. If an item does not relate to you, write "NA" meaning Not Applicable.

Date: _____
Therapist: _____

Client Information:

Name:_____
Date of Birth:_____ Age: ____
Address:_____
City/State:_____ Zip:_____
Home Phone: _____Cell Phone: _____Work Phone:_____
Other Numbers :_____
Last 4 digits of SS#: _____
Best E-mail address to reach you: _____
Who is responsible for payment:_____
Have you been to this Counseling Center before? Yes____ No____
If yes, please list dates and counselor(s):_____
How did you hear about the counseling services?_____
Please describe the reason for your visit today:

_____

_____

_____

Social Information:

Marital Status: o Never married o Married o Separated o Divorced
o Other-_____
How long have you been in your current marriage?_____
Total number of Marriages: Self: _____time(s) Date(s):_____
Spouse: _____time(s) Date(s):_____
Spouse's Name:_____
Date of Birth:_____ Age: ____

Children:
(Self): Name_____ Age____ Sex___ Name_____ Age_____ Sex____
Name _____ Age____ Sex___ Name_____ Age_____ Sex____
(Spouse): Name_____ Age___ Sex___ Name _____ Age____Sex_____
Name_____ Age___ Sex___ Name_____ Age_____ Sex_____

I presently live with:_____. How would you describe your current living situation?

_____

_____

Highest Education Completed: Self_____Spouse:_____
Employer (Self): _____Position:_____ Length:_____
Employer (Spouse):_____ Position:_____ Length:_____

How would you describe your current work situation?

_____

How would you describe your spouse's current work situation?

_____

Medical Information:
Do you have any medical problems? o Yes - o No
Describe:_____
Treating Physician:_____
Specialty:_____
Date of Last Physical:_____
List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication):

_____

_____

Have you ever been prescribed medication for a psychiatric diagnosis? o Yes - o No
If yes, list medication (even if you are no longer taking it)_____

_____

Have you received counseling previously? o Yes - o No
When, where and reason:

_____

Are you currently under the care of a mental health professional (i.e. Psychiatrist, Psychologist, or Counselor)? o Yes - o No Describe:_____

Do you or your family have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? o Yes - o No If yes, describe_____
_____

Do you or your family have any history of drug/alcohol abuse? o Yes - o No
If yes, describe_____

Is there any history of sexual abuse or physical abuse toward you? o Yes - o No
If yes, describe

_____

Have you ever experienced any situation that you would consider TRAUMA:

_____

Please complete the following sentence

Today I feel

_____

My marriage

_____

Fun for me

_____

Growing up with my family

_____

If I could change one thing

_____

Six months from now

_____

God is

_____

What I hope to gain from counseling

_____

Any other important information about yourself:

_____

_____

_____

_____

Name of client: DOB:

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON- SECURE MEANS

I, AUTHORIZE: MARTIN COUNSELING, PLLC 472 PARK GROVE DR. Katy, TX 77450 TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY/MY CHILD'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments
O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
O My health record, in part or in whole, or summaries of material from my health record
O Other information. Describe: _____

BY THE FOLLOWING NONSECURE MEDIA:

O Unsecured email.
O SMS text message (i.e. traditional text messaging) or other type of "text message."
O Other media.
Describe:_____.

TERMINATION O This authorization will terminate _____ days after the date listed below. OR
O This authorization will terminate when the following event occurs:

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my/my child's protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Signature of client, parent, guardian Date

Credit Card Authorization Form

I authorize **Martin Counseling, PLLC** to charge this credit card for services rendered, in the case of a missed appointment, or an appointment not canceled within 24 hours of a scheduled session.
I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Client Signature Date

Name as it appears on Card: _____

Credit Card #:_____

CCV: _____ Expiration Date: _____

Billing Zip Code: _____

Thank you for completing the intake form.