New Client – Couples or Family Counseling Intake Form

Mt. Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

Welcome! Please provide the following information. Each partner or family member should complete a separate form. The information you provide here is protected as confidential information.

Name: _____ Date of Birth_____ Age:_____ Today's Date: _____

Address: _____ City_____ State/Zip _____

Phone: (home) _____ May we leave a message? ____yes __no

(cell)_____ May we leave a message? ____ yes __no

Email: _____ May we leave a message? ___yes ___no

Emergency Contact Person_____Phone_____ Relationship?_____OK to contact? Yes__ No__

Your Occupation: _____ Employer: _____

If student, please list school, field of study, and degree toward which you are working:

_____

Member of Mt. Olivet Church? Yes [ ] No [ ]

How did you hear about Mt Olivet Counseling Service?_____

Have you previously seen a counselor at Mt. Olivet Counseling Service? [ ] Yes [ ] No If so, when?_____

Relationship Status:

( ) Single
( ) Long term relationship for _____ years
( ) Married for _____ years
( ) Separated after a marriage of _____ years
( ) Divorced for _____ years after a marriage of _____ years
( ) Remarried for _____ years
( ) Widowed after a marriage of _____years

Spouse/Partner's name: _____ Age:_____ Occupation: _____

Your Family Information:

First name, date of birth, and gender of any children or step-children you have:

1)_____ Age__ d.o.b____ 2) _____ Age__ d.o.b____ 3)_____

age ___d.o.b._____ 4)_____ age__ d.o.b_____ 5)_____ age __d.ob. ____

6)_____age __ d.o.b._____

Are there any co-parents or step-parents involved in your children's care? [ ] Yes [ ] No

If yes, names of co-parents or step-parents:

_____

With whom do you live? _____

Family of Origin Information:

Father's name _____ Alive? _____ Age:____ Occupation: _____

Mother's name _____ Alive? _____ Age: ____ Occupation: _____

What is/was your parent's marital status? ( ) married ( ) divorced ( ) separated

( ) father remarried ( ) mother remarried ( ) parents never married

First name, age, and gender of any siblings and stepsiblings you have:

New Client – Couples or Family Counseling Intake Form

Mt. Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult

Name: _____ Age: _____ Date: _____

Gender: [ ] Female [ ] Male [ ] Transgender [ ]Non-Binary [ ] Other.

Preferred Pronouns: [ ] She/her/hers [ ] He, him, his [ ]They/them/their

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem **during the past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day.	
I	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6. Feeling nervous, anxious, frightened, worried or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V	9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs?)	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12. Hearing things other people couldn't hear, such as voice even when on one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could what another person was thinking?	0	1	2	3	4	
VIII	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15. Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	0	1	2	3	4	
X	16. Unpleasant thoughts, urges or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g. painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquillizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents	0	1	2	3	4	

New Client – Couples or Family Counseling Intake Form

Mt. Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

	(like glue) or methamphetamine (like speed)?						

INFORMATION FOR CLIENTS & INFORMED CONSENT

Mental Health History:

Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
_____	_____	_____
_____	_____	_____
_____	_____	_____

What did you find most helpful in therapy?
_____
What did you find least helpful in therapy?
_____
Have you ever been hospitalized for psychiatric reasons? ( ) Yes ( ) No
Is there a history of mental illness in your family? ( ) Yes ( ) No
If yes, please elaborate_____
_____
Have you ever had thoughts about harming yourself? ( ) Yes ( ) No
Have you ever engaged in self-harm behaviors? ( ) Yes ( ) No
If so, explain _____
Have you ever had thoughts of harming others? ( ) Yes ( ) No
Do you have any history of aggression toward others? ( ) Yes ( ) No
If yes, please explain _____

What is your **faith/spirituality history**?_____

Medical Problems & Medication: Please list any current medical issues you are facing and medication (and dosage) you are taking: _____
_____
Hospitalizations? _____
Most Recent Physician's Physical?_____

Substance Use: Please check substances you use on a daily, weekly OR monthly basis:

( ) Alcohol How many drinks per day___, week or ___ month ____?
( ) Marijuana Use per day___ week ___ or month ____?
( ) Caffeine How many drinks per day___ week ___ or month ____?
( ) Tobacco, type: Use per day___ week ___ or month ____?
( ) Cocaine Use per day___ week ___ or month ____?
( ) Opioids Use per day___ week ___ or month ____?
( ) Amphetamine/speed Use per day___ week ___ or month ____?
( ) Other & amount used: _____

Do you believe your use may be a problem? yes ( ) no ( ) Please describe: _____

CAGE ASSESSMENT:
Have you ever felt you needed to **C**ut down on your chemical use? yes ( ) no ( )
Have people **A**nnoyed you by criticizing your drinking? yes ( ) no ( )
Have you ever felt **G**uilty about drinking? yes ( ) no ( )
Have you ever felt you needed a drink first thing in the morning

(**E**ye-opener) to steady your nerves or get rid of a hangover? yes ( ) no ( )
Have you ever been assessed/treated for chemical related problems? yes ( ) no ( )
Any chemical-use related legal problems? yes ( ) no ( )
Family history (__grandparents, __parents, __siblings) of substance abuse? yes ( ) no ( )

Significant Cultural History or issues you feel are important for your therapist to know:

_____

Education: Please indicate your highest education level:
( ) Less than high school ( ) High school equivalent/GED ( ) High school diploma
( ) Vocational ( ) Some college ( ) Bachelor's degree
( ) Master's degree ( ) Doctoral degree ( ) Other:
Major/minor/area of concentration _____
Any learning problems in school? yes ( ) no ( ) If yes, please describe:
_____

Personal Strengths:
What do you do well and what activities do you enjoy, or what personal qualities would others say you have?
_____
_____
What kinds of support systems (connections) do you have in your life?
_____

What strengths do you believe your relationship/family has?
_____

What issues challenges your relationship the most right now, or led to your decision to seek couples/ family counseling?
_____
_____

What solutions have you tried to cope with these issues?
_____
_____

On a scale of 1-10, how happy are you in your current couple or family relationship?
☹ 1 2 3 4 5 6 7 8 9 10 ☺

What do you hope to gain from couples/ family counseling (changes sought)?
_____
_____

Legal or Financial Issues: Please list any that are affecting you or your family right now, or which have had a significant impact on you in the past?
_____
_____

New Client – Couples or Family Counseling Intake Form

Mt. Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

Couples/Family Relationship Concerns: (Please check any relationship concerns you currently have)

( ) Fighting
( ) Feeling distant
( ) Loss of fun
( ) Lack of honesty
( ) Physical fights/abuse
( ) Educational problems
( ) Disagreement about parenting
( ) Disagreement about sexuality
( ) Emotional Abuse
( ) Disagreeing about relatives and/or friends
( ) Conflict with relatives and/or friends
( ) Alcohol use
( ) Drug use
( ) Other Addictions_____
( ) Infidelity
( ) Money ( ) Other:_____
( ) Disagreement about role of social media

Is there anything else you think would be helpful for your counselor to know?

_____
_____

Please read the following information about our program, and sign the last two pages.

Couples or Family Intake Form
Mt. Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

INFORMATION FOR CLIENTS & INFORMED CONSENT FOR COUPLES/FAMILY THERAPY

APPOINTMENTS AND SCHEDULING:

All appointments are scheduled with our Office Manager, Anne Lied, either in person at the office or by calling 612-927-7335. Press 10 to leave her a voice mail. It is your responsibility to schedule your appointments and keep them. Usually we suggest that you set up a series of appointments to begin as soon as our schedules permit. Please be alert to how many appointments remain in your series and discuss your scheduling options as needed with your clinician. Psychiatric consultations are scheduled one appointment at a time. **We are not a crisis center.** The telephone is answered Monday through Friday, usually during business hours. If you are in crisis or believe a crisis may arise, please call 911. We do offer some evening appointments.
Sessions are 50 minutes long. If a client is late for their appointment, the appointment time will not be adjusted.

FEES

Fees for members of Mount Olivet are $40.00 per session for counseling services.
Fees for non-members are $80.00 per session.
We do not work with third party payers/insurance companies.

Please contact Anne 24 hours in advance of the scheduled appointment time, if you need to cancel, so that your time can be given to someone waiting for an appointment. **A no-show, or a cancellation later than 24 hours prior to the scheduled appointment will be charged the session fee.** We reserve the right to decline scheduling of future appointments if there is a pattern of cancellations or no-shows.

We do not send out monthly bills or keep record of payments. You are asked to pay for each session as it occurs unless you make other arrangements, and to ask for a receipt if you believe you will need one. If you are unable to pay the full fee please ask Anne for an Application for Financial Assistance on which you can indicate the amount you are able to pay, with a minimum payment of $10.00 per session.

E-MAIL & SOCIAL NETWORKING POLICIES

All appointments are scheduled with our Office Manager, **Anne Lied,** either in person at the office or by calling 612-927-7335. Press 10 to leave her a voice mail. Please do not email your therapist information related to your therapy sessions, since email is not completely secure or confidential. If you send an email, we will only respond for purposes of scheduling or appointment reminders. Be aware that all e-mails are retained in the logs of your and Mt. Olivet Counseling Service's Internet service providers. While it may be unlikely that someone reads these, they are available to be read by the system administrator of the Internet service provider. You should also know that any e-mails we receive from you become a part of your legal and therapy records**. Please do not use SMS (texting), Twitter, Facebook, or LinkedIn to contact your therapist. These sites are not secure**. We do not accept friend requests or contact requests from current or former clients on any social networking site, since adding clients as friends or contacts can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please ask your therapist when you meet.

CONFIDENTIALITY:

The fact that you are a client ensures that all information about you, as well as the content of your sessions and phone conversations, will be held in strict confidence with the following possible exceptions:

- If you sign a Consent for Release of Information form, you authorize us to communicate specified information about you with one or more specified professionals or agencies outside of this office;
- In order to ensure the best possible care, the interns and professional staff meet regularly to consult and collaborate regarding client care;
- If your records are subpoenaed by signature of a judge, we are required to release them to the court; the therapist will not agree to testify in legal matters related or unrelated to therapy.
- If you are using, mood-altering drugs including alcohol, while pregnant, we are required to report this information;
- If you are a minor (under age 18), your parents have access to your records, unless:
  - You are emancipated, (living away from home and paying your own way)
  - You are pregnant, or
  - You are in danger of harm from one or both of your parents;
- If you have previously had inappropriate sexual contact from any health care provider, and if you reveal the name of such provider, we are mandated to report this information to the appropriate licensing board;
- In the course of your session, if we have reason to suspect the abuse of a child or of a vulnerable adult, we are required by law to file a report of the alleged abuse to the appropriate county or state agencies. This report is required whether the alleged abuse occurs within your family or outside of it;
- In the course of your sessions, if, after careful and thoughtful consideration, we come to believe that there is a clear and imminent danger of your physically harming yourself or another person, we will take steps to prevent such potential harm, steps which will violate your confidentiality.

PHILOSOPHY:

In most situations, the therapist's role is that of a consultant. The therapist's job is to help you think about what your problems are and explore possible solutions to your problems. The therapist will listen to you and give feedback about what he/she hears and what the therapist thinks your options are. Although the therapist will explore options with you, rarely will the therapist tell you what to do, because the decision and the responsibility to make changes in your life needs to be yours. Your job is to be more open and honest about yourself than you are in social relationships and to be committed to the process of couples counseling and honest with each other. You are responsible for deciding what to talk about in each session and deciding what your goals are.

During the course of therapy, the therapist is likely to draw on various psychological approaches which stem from the nature of the problem and the assessment of what will best benefit you. These approaches include behavioral, cognitive behavioral, dynamic, existential, system/family, developmental, or psycho-educational. If you are not getting what you want, you have the right to ask for other treatments or for a referral to other professionals. If the therapist believes he/she is not being helpful to you, the therapist also has an obligation to help you find someone who might be more helpful. You may terminate treatment at any time.

Referrals: We reserve the right to refer a client to a more appropriate type of therapy with other therapists if we assess that your needs are not likely to be best served by our staff.

Referrals to our Psychiatrist or Internist at Mt. Olivet Counseling: Clients are referred to our psychiatrist or internist only internally while maintaining a counseling relationship with one of our therapists.

LIMITATION ON CONFIDENTIALITY WHEN PROVIDING THERAPY TO COUPLES/FAMILIES:

There are different expectations and limits about confidentiality in relational therapy than there are in individual therapy. When the therapist agrees to treat a couple or family, the therapist considers the relationship between the couple/family members to be the client and hence the couple/family is the client. For instance, if there is a request for the treatment records of the couple, the therapist will need the authorization of both/all members before releasing confidential information. Also, if the therapist's records are subpoenaed, the therapist will assert the psychotherapist-patient privilege on behalf of the couple/family, not just an individual.

During the course of work with a couple/family, the therapist may see either individual alone for one or more sessions. These sessions are a part of the therapy for the couple/family, unless otherwise indicated. Generally, these sessions are confidential in the sense that the therapist will not release any confidential information to a third party unless required by law to do so or unless the therapist has your written authorization. Since individual sessions in the context of couple/family therapy can and should be considered a part of the treatment of the couple, the therapist will also seek the authorization of the other individual/s before releasing confidential information to a third party.

However, be aware that the therapist may need to share information learned in an individual session with both members of the couple, if determined in the best judgment of the therapist that it is important to share the information to effectively serve the therapy of the couple. The therapist will use his/her best judgment about such disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure. **Thus, if it is important to you to talk about matters which you don't want to share with anyone else, you might want to consult with a different therapist who can treat you separately.**

This **"no secrets"** policy is intended to allow the therapist to treat the couple/family more effectively by preventing, to the extent possible, a conflict of interest that might arise if an individual's interests are not consistent with the interests of the couple/family being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple. If the therapist is not free to exercise his/her clinical judgment regarding the need to bring this information to the couple during their therapy, the therapist might be placed in a situation where the therapist will have to terminate treatment. This policy is intended to prevent the need for such a termination.

INFORMED CONSENT FOR COUPLES/FAMILY THERAPY

I understand that couples/family therapy begins with an evaluation of my relationship history and current concerns. While the therapist is evaluating whether he/she is the appropriate therapist for the relationship, he/she will decide whether to begin couples therapy. The therapist understands because of the commitment of time and money as well as the potential impact on the relationship, that is important for me to make an informed choice for a couple/family's therapist.

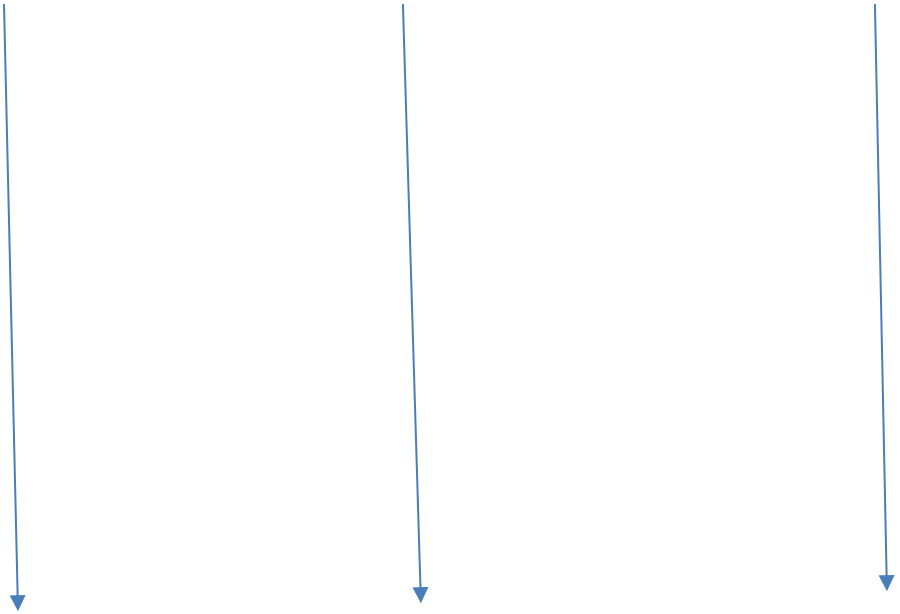
I understand the policies described in the information for clients and Informed consent for couple's/family therapy forms and accept them as conditions for beginning therapy with the therapist. I have read (or heard a verbal communication) of the limits of confidentiality, including those of the therapist, and of the State of Minnesota, and have a copy to keep. I have been given the chance to ask questions and discuss confidentiality and disclosure policies with the therapist. I understand that if my spouse/partner or I communicates information to the therapist individually, whether on the phone or in an individual session, that information may not be held as confidential, and may be shared at the therapist's discretion with the spouse/partner in a subsequent couple's session.

I also understand that the information discussed in therapy is for the purpose of therapy only and is not intended to be used in legal proceeding between me and others, including my partner/spouse/family members. I agree that the role of the couple/family therapist, is to be limited to that which will therapeutically benefit the relationship, and that I will not attempt to gain an advantage in any legal proceeding from my therapy. I agree not to ask the therapist to testify in court, whether by person, or by affidavit. I also agree to instruct my attorneys not to subpoena the therapist. I understand that this agreement may not prevent a judge from requiring the therapist's testimony, even though he/she will work to prevent such an event. If the therapist is required to appear as a witness, the party responsible for his/her participation agrees to reimburse him/her or MTOCS at the rate of $200 per hour for the time spent traveling, preparing reports or any other case related costs.

I agree to share responsibility with the therapist for the therapy process, including goal setting and termination. By entering into couple/family therapy, I understand that working toward change and engaging in the process of therapy has some risks. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, fear, or experiencing anxiety, depression, insomnia, etc. The therapist may challenge some of my assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that could cause me to feel upset, angry, depressed, challenged, or disappointed.

I understand that attempting to resolve issues in my relationship may result in changes that were not originally intended. I have been informed that couples therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships, although those decisions will always be mine to make. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. I understand that there is no guarantee that couples/family therapy will yield positive or intended results. I accept that the changes that I, or my partner/spouse/family members, make, may have an impact on me, them, and others around me. I accept that these changes can have both positive and negative effects and agree to clarify and evaluate the potential consequences of these changes before continuing with them.

PLEASE SIGN THE FOLLOWING PAGE AS ACKNOWLEDGEMENT THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMED CONSENT INFORMATION.



Couples/Family Intake Form
Mt. Olivet Lutheran Church Counseling Service
1804 West 50th Street, Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386
612-927-7335

INFORMED CONSENT FOR EVALUATION AND TREATMENT

I acknowledge that I have read and received a copy of the INFORMATION FOR CLIENTS and the policy of INFORMED CONSENT FOR COUPLES/FAMILY THERAPY, and that I enter into therapy in agreement with this policy

Printed Name of Client _____**Date** _____

Signature of Client_____

Printed Name of Client _____**Date** _____

Signature of Client_____

Printed Name of Client _____**Date** _____

Signature of Client_____

Printed Name of Client _____**Date** _____

Signature of Client_____

Printed Name of Client _____**Date** _____

Signature of Client_____

***This form is valid for one year from date indicated*.**

PAYMENT AGREEMENT

I agree to pay for each session at the time of session. I will provide notification to the Counseling office prior to 24 hours before the scheduled appointment time if I need to cancel my appointment.
I understand that a **no-show, or a cancellation later than 24 hours prior to the scheduled appointment will result in my being charged the session fee.**

Signed _____ **Date _____**

Signed _____ **Date _____**

Couples/Family Intake Form
Mt. Olivet Lutheran Church Counseling Service
1804 West 50th Street, Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386
612-927-7335

LEGAL WAIVER
FOR COUPLE/FAMILY THERAPY

This contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony or their records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case.

Both parties agree that the goal of counseling, with individual, marital, or couples therapy, is for the sole purpose of the improvement of psychological and relational distress and that the process of therapy depends on trust and openness during therapy sessions.

Therefore, it is understood by both parties that if they request my services as a therapist, they are expected not to use information given to me during therapy sessions for any legal purposes.

I agree that I will not, either solely or with my spouse, enlist our counselor in any legal proceedings related to our current case. I further agree that neither our counselor's records or our counselor's testimony will be subpoenaed for deposition or testimony, and that our counselor will be exempt from conversations with social service personnel, attorneys or members of the justice system. Our counselor's sole responsibility in working with me is as a therapist.

The signatures below reflect that I agree to the terms set forth above.

Signed and Dated_____

Signed and Dated_____

Signed and Dated_____

Signed and Dated, Therapist_____