Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services
5855 Jimmy Carter Blvd., Suite 200, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

COUPLES INTAKE FORM

I. DEMOGRAPHIC INFORMATION

Name:_____ Date: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Address: _____

Telephone: _____ Can we leave a message? [ ] Yes [ ] No

Why are you looking for couples therapy now?

_____

_____

_____

_____

II. FAMILY HISTORY

Marital Status: ☐ Separated ☐ Single ☐ Partnered ☐ In a relationship

☐ Divorced ☐ First marriage ☐ Married after a divorce or separation

Name of spouse or partner_____ Age_____ Originally from? _____

When and where did you start dating? _____ How long have you been living together? _____

If you ever lived with an ex-partner or married, how long did that relationship last?_____

Did you experience any type of abuse in your previous relationships? [ ] Yes [ ] No Type of abuse? _____

Did you have children in your previous relationship? [ ] Yes [ ] No How many?_____

List the following information about your children and your partner's children:

Name	Sex	Age	Biological or adopted	Living with You?	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Check any of the following that apply to you and explain

___ Depression _____

___ Alcohol _____

___ Drug abuse _____

___ Other addictions _____

___ Serious illness _____

___ Violence _____

___ Suicide thoughts _____

___ Homicidal thoughts _____

Are these issues currently being treated? [ ] yes [ ] No

Describe your current or past treatment: _____

_____

How will you know if couples therapy is successful? Realistically, how long do you think this might take?

_____

_____

III. MEDICAL HISTORY

How would you rate your current physical health?

[ ] Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very good

Please list any specific health problems you are currently experiencing

_____

Are you currently taking any prescription medication? List your medications:

_____

_____

IV. DEVELOPMENTAL HISTORY

List any problems during pregnancy, birth, deliver, childhood or adolescence:

_____

_____

_____

List what best describes your childhood

____ Happy childhood
____ Emotional problems
____ Drug abuse
____ Medical problems
____ Witnessed domestic violence between parents
____ Physically abused
____ Sexually abused
____ Other problems: _____

____ Eating disorders
____ Problems in school
____ Family problems
____ Unhappy childhood
____ Legal problems
____ Behavioral problems
____ Alcohol abuse

People currently living with you: _____

Social/ family support system: _____

Spiritual or religious life: _____

Recreational/ hobbies, interests & leisure activities: _____

_____

V. EDUCATIONAL HISTORY

List highest grade achieved and place: _____

VI. OCCUPATIONAL/ EMPLOYMENT HISTORY

Jobs (responsibilities, full time or part time): _____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Check all that apply:

[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflict
[ ] unstable work history
[ ] disabled
[ ] medical disability
[ ] supervisor conflict
[ ] on the job stress
[ ] sexual harassment at work
[ ] discrimination at work

_____

VII. HISTORIA LEGAL – LEGAL HISTORY

Any legal problems? Arrests? _____

VIII. MARITAL RELATIONSHIP

Relevant Sexual History (if sexual history is not relevant to the current situation or if you feel that you do not want to answer any of these items, please go to the next section):

[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age of first sexual experience
[ ] sexual dysfunctions
[ ] any treatment for sexual dysfunctions
[ ] sexual problems related to medications
[ ] medical diagnosis
[ ] age of first pregnancy/fatherhood
[ ] engage in unprotected sex
[ ] engage in protected sex

For each of these topics, please write a sentence or two about how you handle these areas of life:

Talking to each other, staying emotionally connected, spending time together

Outside stressors spilling over into your relationship

Irresolvable disagreements and gridlocks

Romance, verbal affection, physical affection

Sexuality and physical intimacy

Major life change events: births, deaths, moves, job losses, illnesses, etc.

Children and co-parenting

Relatives and in-laws

Infidelity, Jealousy, flirtation

Disagreements, fights, anger

Differences in your values and preferences

Very hard events: violence, alcohol, drugs

Teamwork on chores, childcare

Decision-making, influence, power-sharing

Finances, spending, saving, financial planning

Recreation, fun, hobbies

Spirituality and religion

ADDITIONAL INFORMATION

Add important /relevant information/ concerns

Counseling Institute of Atlanta, Inc.
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INFORMED CONSENT FOR COUPLES THERAPY SERVICES

Welcome to the Counseling Institute of Atlanta, Inc., for counseling services. Thank you for trusting us to assist you with your personal concerns. It is our desire to help you in this moment of your relationship. We are honored that you have chosen us as your couples' therapist. We will do everything we can to help you move forward and solve your problems. Please take the time to read and sign this form. Make sure you read and understand this document. If you have any questions, do not hesitate to ask your therapist.

LIMITATIONS OF SERVICES: I understand that the Counseling Institute of Atlanta, Inc.'s services are limited to counseling services including assessment, consultation, therapy, and intervention. I understand that intervention services may include counseling and psychotherapy. I understand that my therapist is not warranting a cure or offering any guarantee of results or improvement of any condition.

The purpose of couples therapy is for clarification, reconciliation and healing and at times of legal action is adversarial by definition. In these cases, no information may be released for either party without written consent of both parties because technically, the relationship is the client. This makes any and all information from the therapy sessions available to both parties of a legal dispute; therefore, I find it in the best interest of the therapeutic process for both parties to agree not to subpoena the therapist for either side in the event of a divorce or custody trial.

ASSUMPTION OF RISKS. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. Your active participation and commitment are important during this process. Some people may need a few sessions and others may need more. Come to our office on time according to your scheduled appointment. If for any reason, you are not able to attend, please let us know in advance so we can use that time with another client.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

I understand that the potential benefits of undergoing counseling services may include obtaining professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of mental health assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation.

LIMITS OF CONFIDENTIALITY: Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client. Even though two people participate in couples therapy, your relationship is considered the client. To release information about your couples therapy, I need to have written releases from both of you. In general, the law protects the confidentiality of all communications between clients and counselors. I only release information about our work with both of your written releases. Clients often give me releases to talk to their individual therapists, and/or previous therapists. This helps me to coordinate your couples therapy so that it will be most helpful to you. Conceivably, one of you might think that my testimony would be helpful to you in a legal proceeding, such as a divorce or custody dispute. Please remember, that my testimony would require written releases from both of you. In couples therapy, information received from either party via phone calls, voice mail, and/or written communication will not generally be kept secret or confidential as this also impedes the therapeutic process and relationship. During the course of my work with a couple, we may see one of you for one or more individual sessions. These sessions should be seen as a part of the work we are doing with the couple. If you are involved in such a session, please understand that generally these sessions are confidential. However, we may need to share information learned in an individual session with your partner/spouse. We will use our best judgment as to whether, when, or to what extent we will share this information. If appropriate, we will first give the partner/spouse being seen individually the opportunity to make the disclosure. Therefore, if you feel it necessary to talk about matters that you absolutely do not want to be shared with your partner/spouse, you may want to seek the services of a therapist who can work with you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple by preventing, to the extent possible, a conflict of interest. For example, information disclosed during an individual session may be relevant or even essential to the proper treatment of the couple. If we are not free to exercise our clinical judgment regarding information that is shared in an individual session, we might be placed in a situation where we have to terminate treatment of the couple. This policy is intended to prevent the need for such termination.

There are also a few situations in which I am legally required to protect someone, even if that involves revealing some information about a client's treatment. 1. Abuse of Children and Vulnerable Adults: If I believe that a child, an elderly person or a disabled person is being abused, I may be required by law to file a report with the appropriate state agency. 2. Duty to Warn and Protect: If I believe that a client of mine is threatening serious bodily harm to another person, I may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. 3. If a client of mine threatens to harm him/herself, I may be required to seek hospitalization for that client or contact family members or others who can help provide protection.

Occasionally, I find it helpful to consult with other professionals about a situation in therapy. In these consultations, I avoid revealing the identity of my clients. I will usually inform you of these consultations.

This is a strictly confidential client mental health record. Re-disclosure or transfer without the client's written consent is strictly prohibited, except as permitted by the law. The client understands that secure and private communication cannot be completely guaranteed through cellphones and e-mail. It is the decision of the client to communicate, or not, through these "non-secure" technologies. If the client uses these "non-secure" technologies to contact the counselor, the counselor will communicate with the client through these "non-secure" technologies as well, until the client indicates otherwise. Please, indicate what type of communication is allowed:

Communication via phone or cell phone _____ Communication via voice message _____
Communication via fax _____ Communication via e-mail _____
Communication via text message _____ Communication via teleconference _____

TERMINATION OF THERAPY: Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. The staff from the Counseling Institute of Atlanta, Inc., will try to contact you, but your case will be terminated/closed if we do not hear back from you. If you are feeling better or planning not to return to therapy, it is important that you come in for a final session, so that we can discuss the reasons leading to the decision, the course of therapy and any relevant referrals. A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan.

STATEMENT OF UNDERSTANDING: I understand the above information and/or have discussed any questions related to the above information to my satisfaction. I agree not to subpoena therapy records in the event of a legal proceeding.
By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

_____

PAYMENT: Our fees are based on a therapeutic hour of 50 minutes for psychotherapy services. We accept cash or credit/debit cards. If you fail to cancel your appointment within two days in advance, you will be charged the full session amount. You will have to pay that session at the beginning of your next appointment or call us to provide your card information. We will try to contact you two days in advance to remind your appointment, but it is your responsibility to cancel or reschedule the appointment on time.

Signature _____ Date _____

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CANCELLATION AND MISSED APPOINTMENT POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed a full session fee for your missed appointment.
You will be automatically charged a full session fee for any missed appointments that are cancelled with less than a 2-day notice. This fee may be waived in cases involving emergencies, but such a waiver is solely at my discretion. A bill will be mailed directly to all clients who do not show up for or cancel an appointment on time.
Thank you for understanding and cooperation.
The signature below acknowledges that I understand and accept the terms and conditions of this policy.

Signature of Client _____ Date _____

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NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT

My signature acknowledges that I was informed and have received a copy from the Counseling Institute of Atlanta, Inc. of the Notice of Policies and Practices to Protect the Privacy of Your Health Information. This notice details the policies that protect the privacy of my personal health information.

I consent to the use and disclosure of my protected mental health information by the Counseling Institute of Atlanta, Inc. for the purpose of providing treatment to me, obtaining payment for the mental health services provided, and/or to conduct other counseling services.

I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with the staff of the Counseling Institute of Atlanta, Inc.

Signature of Client _____ Date: _____

Client's printed name: _____ Date of Birth: _____