Personal
Groups
Training

1612 S. Big Bend Blvd. St. Louis, MO 63117
(314) 529-1391

Personal Information Form For Couples

Today's Date: ____________ How did you hear about us? __________________________________

Partner #1 Information *(Please enter Partner #2 information below)*

Name: ____ Date of Birth:__________________________
Home Phone #: (____)_________________________Cell Phone #: (____)__________________________
Address: ____
E-mail address: ____
Education: High School College Other______________________
Employer: __________________________ Position: _________________ How Long Employed?________
Do you attend church? Y/N Church Name ____________________________________ Member? Y/N
Relational Status: Engaged / Married / Divorced / Separated / Committed Relationship

Partner #2 Information

Name: ____ Date of Birth: ______________
Home Phone #: (____)______________________Cell Phone #: (____)________________________
Address (if different than above):____
E-mail address: ____
Education: High School College Other______________________
Employer: ________________________ Position: _______________ How Long Employed?________
Do you attend church? Y/N Church Name ____________________________________ Member? Y/N
Relational Status: Engaged / Married / Divorced / Separated / Committed Relationship

Emergency Contact Information

Name: ____________________________ Phone: ___________________ Relationship: ____________

Information About Children

Please list: *Name, Age, Sex, Living at home, and note if they are your biological, step, or adopted child*

____
____
____
____

What is happening in your life that has caused you to seek out counseling?

____
____
____
____
____

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Partner #1 Health and Family History

Your current health: Very good Good Average Declining
Approximate date of your last comprehensive medical exam: ________________
Current medical problems:____

____

Medication	Reason For Medication	Dosage	Frequency	Prescribed By

Are you currently meeting with any of the following: Counselor | Psychologist | Psychiatrist | Dietitian | Other: __________ If so, please list their name and reason: ____

____

Have you previously sought counseling or psychiatric help? ____Yes ____No
If so, please tell me a bit about it and how satisfactory your experience was:__________________________

____

____

Please describe any family history of medical and / or psychological problems:________________________

____

____

____

Have you ever experienced: *(Place a check mark by conditions that apply to you)*
___ Anxiety ___ Eating Disorder ___ Depression ___ Anger ___ Abandonment
___ Addiction (drugs, alcohol, sex, gambling, pornography, etc.) ___ Adoption Issues
___ Post Traumatic Stress Disorder ___ HIV Positive ___ Postpartum Depression

Please describe any current or past addiction(s) (i.e., drug, alcoholic, sexual, etc.):______________________

____

____

Please describe any current or past violence or abuse in the home: _________________________________

____

____

____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that bring you to counseling (your relationship with your parents, their relationship with each other, significant losses and / or events): ____

____

____

____

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Social History
How satisfied are you with your social support system? ________________________________
Do you drink alcoholic beverages? Y/N If so, how much per week? ________________________
Do you use drugs (illegal/any drug)? Y/N If so, how often and which drug? ________________

Please circle any symptom you have had in the **past six months**:

Change in appetite	**Problems concentrating**
Difficulty sleeping	**Low Motivation**
Sleeping too much	**Isolating from others**
Fatigue/low energy	**Frequent anger**
Low self-esteem	**Depressed mood/sadness**
Tearful/cry spells	**Anxiety/Fear**
Hopelessness	**Panic**

Partner #2 Health and Family History

Your current health: Very good Good Average Declining
Approximate date of your last comprehensive medical exam: ______________
Current medical problems:____
____

Medication Reason For Medication Dosage Frequency Prescribed By
____
____
____
____

Are you currently meeting with any of the following: Counselor | Psychologist | Psychiatrist | Dietitian | Other: __________ If so, please list their name and reason: ____________________________
____

Have you previously sought counseling or psychiatric help? ____Yes ____No
If so, please tell me a bit about it and how satisfactory your experience was:________________
____
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Please describe any family history of medical and / or psychological problems:_______________
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Have you ever experienced: *(Place a check mark by conditions that apply to you)*
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___ Addiction (drugs, alcohol, sex, gambling, pornography, etc.) ___ Adoption Issues
___ Post Traumatic Stress Disorder ___ HIV Positive ___ Postpartum Depression

Please describe any current or past addiction(s) (i.e., drug, alcoholic, sexual, etc.):______________________
____
____

Please describe any current or past violence or abuse in the home: ________________________________
____
____
____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that bring you to counseling (your relationship with your parents, their relationship with each other, significant losses and/or events): ____
____
____
____

Social History
How satisfied are you with your social support system? ____
Do you drink alcoholic beverages? Y/N If so, how much per week? ______________________________
Do you use drugs (illegal/any drug)? Y/N If so, how often and which drug? _________________________

Please circle any symptom you have had in the **past six months**:

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Hopelessness	Panic

Avenues Counseling

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Consent for Treatment

Client Name: ______________________________ Date of Birth: _______________

Client Name: ______________________________ Date of Birth: _______________

I give permission to **COURTNEY HOLLINGSWORTH, LPC (License # 2009036286)** to provide counseling to me. As a client of Avenues Counseling it is your right to have the content of your therapy sessions held in confidence with these exceptions in which we are mandated to report: (1) if you sign a release form for us to divulge any or all information, (2) if you intend suicide, or if you intend to do serious physical harm to yourself, (3) if you intend homicide, (4) if a child, elderly person, or disabled person is being abused or has been abused, or (5) in the case of exploitation by a mental health professional.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person. In following ethical and professional standards, our therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

I have read and agree to the above policies, procedures and statements.

______________________________ ______________________________
Signature of Client Printed Name of Client Date

______________________________ ______________________________
Signature of 2nd Client Printed Name of Client Date

______________________________ ______________
Signature of Counselor Date

We ask that both Partners Initial the Statements Below

Contact *Please INITIAL each statement to which you consent*
____ I grant permission for general information (events and other information) to be sent to my home address.
I grant permission for my therapist and the administrative staff to leave a message for me at
___home phone ___cell phone ___business phone

I recognize that e-mail & text is not a secure means to transmit data. I voluntarily waive my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications (and / or invoices) from Avenues Counseling via e-mail or text. I voluntarily give my permission and will not hold Avenues Counseling or my counselor, Courtney Hollingsworth, legally responsible for the transmission of this data.

Client Signature______________________________Date_______________

Client Signature______________________________Date_______________

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____ I grant permission to send and receive communication from my therapist and Avenues administrative staff at my email address.

Privacy Policy *Please INITIAL*
_____ I acknowledge that the Notice of Privacy Practices has been made available to me.

Financial Policy *Please INITIAL all statements*
_____ I understand that counseling sessions are 50 minutes long. The fee for a 50 minute session, either face-to-face, by phone, or Skype (e.g. telehealth) is $_____ as determined by you and your counselor. **Your counselor charges in 15 minutes increments for all phone sessions.**

_____ I agree to make payment at the beginning of the session. I understand that my counselor receives a percentage of the fee I pay to Avenues for our time together and is not compensated for his/her time with me unless and until I make payment for a session. Fees per session are subject to change. If changes are forthcoming, you will be given 30 days notice prior to the implementation of the change.

_____I understand that Avenues Counseling prefers payment to be made in the form of cash or check. As a convenience Avenues also accepts credit cards, for which there is a convenience charge.

_____I agree that in cases of returned checks and bank fees, to pay for all service charges associated with my account and for all returned checks. There is a $20 fee for all returned checks.

____ I understand that if I have an outstanding balance billing information will be sent to my primary address unless another address is supplied.

Missed Appointment Policy *Please INITIAL*
_____I understand that **24 hours notice** is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged your full fee. If you have a credit card on file, your missed appointment will be charged to your credit card.