Marie Krebs Consulting 469-212-9897

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INTAKE FORM

Name				Date			
_	first	middle initial	last				
Address:				Date of Birth	Age		
st	treet	city	zip				
		sessions please indicate you	ur preferred form	of communication:			
_	home	work		cell/mol	oile		
Email Address:_			Check here if it is	s ok to leave you a m	essage		
Who Referred yo	ou?		Phone #				
CHECK HERE IF	YOU PLAN TO	PAY FOR THERAPY YOURSE	LF				
PLEAS	SE FILL OUT TH	S SECTION IF SOMEONE EL	SE WILL BE PAY	ING FOR YOUR THEF	RAPY		
Name		Te	Telephone Number				
Address							
Street		city	state	:	zip		
Email Address							
What is this pers	son's relationsh	ip to you?					
check at each the clear answers to negotiated fee for least 24 hours be know that if some responsible part	nerapy session. I any questions I any appointm I fore the sched I eone else is res I sted above c F \$25.00 WILL E	I understand my fee is	n told how this fe lso means that I a not show for (i.e. a cancel"). My sign therapy fees that balances. All cho	e is determined and lam responsible for pa am responsible for pa a "no show") or fail to nature also acknowle Marie Krebs may con ecks are made payab	I have received aying the full o cancel at edges that I stact the le to: Marie		
Signature:			Date:				

INFORMATION ABOUT YOUR FEE:

POLICY: A Sliding Fee Discount Program will be provided to eligible individuals on the basis of their ability to pay. The ability to pay will be determined by the household annual income and family size. Only individuals living in households with income below 200% of the Federal Poverty Level will qualify for Sliding Fee Discount. Payment is expected (in exact cash or personal check) at the time of service. I do not believe it is helpful to your counseling experience to add the stress of accumulating a balance for therapy. Marie offers a limited number of sliding scale treatment appointments.

Briefly explain what brings you to counseling?	
How long have you considered counseling?	
What finally helped you decide to come?	
	No (Please explain)
Who or what have you lost of major significan	ce in the past five years?
Are issues related to God, faith or spirituality i yes, please describe on the back of this page)	important to consider in your counseling?Yes No (if
Describe your current occupation (job, volunted ls your occupation satisfying to you?Yes _No (Please explain)	eer work, school, etc.) No Are you satisfied with your current social life? Yes
Have you had counseling or psychiatric care in those with whom you were in treatment, the date	n the past? Yes No (If yes, please list the names of ates and length of treatment)
	al conditions? Yes No. If yes, (please describe and
When was your last physical?	
Please list all the medically prescribed prescri	ptions you are taking, and their dose:
pattern of use (number of times a day/week/me	
Pattern c	
Tobacco	
Caffeine	Amphetamines
Pain pills	Ecstacy

Tranquilizers	Other
RELATIONSHIP INFORMATION:	
(Please check the one that applies	to you and how long have you been in this relationship status?
Single Engaged Long Widowed	g-term committed relationship Married Separated Divorced
If in a relationship, what is your pa Please list the first names and age	es of any children currently living in your home:
Children living away from home:_	
Your birth order: Only child	I Oldest Child Middle childYoungest child
IMPORTANT FAMILY HISTORY:	
	on family life. Please check which of the following events occurred in your u, or that you witnessed. After each you have checked, please briefly describe
Physical Abuse (received o	r witnessed)
Emotional abuse	
Verbal Abuse	
Sexual abuse	
Neglect or abandonment	
Suicide	
Homicide	
Drug or alcohol abuse	
Domestic violence	

Please list other events you believe had an important effect on your family or you:
PLEASE USE THE FOLLOWING SPACE TO PROVIDE ANY ADDITIONAL INFORMATION THAT YOU BELIEVE WOULD BE HELPFUL TO ME IN UNDERSTANDING YOU BETTER.
YOU CAN EITHER EMAIL THIS FORM TO ME IN ADVANCE OF YOUR APPOINTMENT, OR BRING IN WITH YOU TO YOUR FIRST APPOINTMENT