



MATTERS OF THE HEART COUNSELING
 243 Old Shackle Island Road
 Hendersonville, TN 37075
 &
 214 North Main Street
 Goodlettsville, TN 37072

COUPLES INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide is held to the same standards of confidentiality as our therapy.

PARTNER A

Name: _____
 (Last) (First) (MI)

Birth Date: ____/____/____ **Age:** ____ **Gender:** Male Female _____
Preferred Pronouns

Address: _____

 (City) (State) (Zip)

Marital Status:
 Never Married Partnered Married Separated Divorced Widowed

Spouse: _____
 (Last) (First) (Middle Initial)

Children's Names and Ages: _____

Primary Phone: () - Emergency Phone: () -

Voicemail? Yes No **Text?** Yes No **Emergency Person:** _____

E-mail: _____ **Please be aware that email might not be confidential.*

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes **Employer:** _____

Job Title: _____ **Length at current Job:** _____

HEALTH & SOCIAL INFORMATION

1. How is your physical health at present? Poor Fair OK Good Excellent
2. How regularly do you use alcohol? Daily Weekly Monthly Rarely Never
3. Do you engage recreational drug use? Daily Weekly Monthly Rarely Never
4. Are you currently in a romantic relationship? No Yes how long? _____
 Quality of your relationship: Poor Fair OK Good Excellent

5. Is there anything in your relationship you would like to mention that may require special consideration or sensitivity from your counselor? (i.e. LGBTQ, Gender Identity, Sexual Trauma, Religious Trauma/Purity Culture, Sexual Behaviors or non-traditional relationship parameters such as polyamory, open marriage, etc.) _____

SYMPTOM RATING SCALE: (rate each symptom: 0=lowest/None 5=High/Worst)

Emotional Symptoms

| | | | | | |
|--------------|-------------|-------------|-------------|---------------|-------------|
| Anger | 0 1 2 3 4 5 | Anxiety | 0 1 2 3 4 5 | Mood Shifts | 0 1 2 3 4 5 |
| Irritability | 0 1 2 3 4 5 | Depression | 0 1 2 3 4 5 | Helplessness | 0 1 2 3 4 5 |
| Hopelessness | 0 1 2 3 4 5 | Frustration | 0 1 2 3 4 5 | Crying Spells | 0 1 2 3 4 5 |
| Emotionless | 0 1 2 3 4 5 | Fear | 0 1 2 3 4 5 | OTHER: _____ | |
| Worry | 0 1 2 3 4 5 | Guilty | 0 1 2 3 4 5 | | |

Mental Symptoms

| | | | |
|-----------------------------|-------------|-----------------|-------------|
| Trouble Concentrating | 0 1 2 3 4 5 | Inattention | 0 1 2 3 4 5 |
| Difficulty Making Decisions | 0 1 2 3 4 5 | Distractibility | 0 1 2 3 4 5 |
| Repeated Neg. Thoughts | 0 1 2 3 4 5 | Memory Problems | 0 1 2 3 4 5 |
| Paranoid Thinking/Behavior | 0 1 2 3 4 5 | Racing Thoughts | 0 1 2 3 4 5 |

Behavioral Symptoms

| | | | | | |
|-------------------|-------------|-------------------|-------------|---------------------|-------------|
| Hyperactivity | 0 1 2 3 4 5 | Purging/vomit | 0 1 2 3 4 5 | Alcohol Use | 0 1 2 3 4 5 |
| Impulsivity | 0 1 2 3 4 5 | Disordered Eating | 0 1 2 3 4 5 | Drug Use | 0 1 2 3 4 5 |
| Arguing | 0 1 2 3 4 5 | Suicidal Thoughts | 0 1 2 3 4 5 | Fighting/Aggression | 0 1 2 3 4 5 |
| Disorganized | 0 1 2 3 4 5 | Self-Injury | 0 1 2 3 4 5 | Lying/Deceitfulness | 0 1 2 3 4 5 |
| Binge/Over Eating | 0 1 2 3 4 5 | Withdrawal | 0 1 2 3 4 5 | Avoiding School/Job | 0 1 2 3 4 5 |

Physical Symptoms

| | | | |
|----------------------------|-------------|--------------------|-------------|
| Appetite Increase/decrease | 0 1 2 3 4 5 | Severe Headaches | 0 1 2 3 4 5 |
| Sleep Difficulties | 0 1 2 3 4 5 | Muscle Tension | 0 1 2 3 4 5 |
| Increased Heart Rate | 0 1 2 3 4 5 | Body Pain/Numbness | 0 1 2 3 4 5 |
| Sweating/Chills | 0 1 2 3 4 5 | Other: _____ | |
| Stomach or Gut Issues | 0 1 2 3 4 5 | | |

CURRENT MEDICATIONS:

| | | | |
|-------|-------|---------------|-------------|
| Name: | Dose: | Treatment of: | Prescriber: |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Counselor Notes: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

| Difficulty | | Family Member |
|-------------------------|--------|----------------------|
| Depression | yes/no | _____ |
| Bipolar Disorder | yes/no | _____ |
| Anxiety Disorders | yes/no | _____ |
| Panic Attacks | yes/no | _____ |
| Alcohol/Substance Abuse | yes/no | _____ |
| Trauma History | yes/no | _____ |
| Suicide Attempts | yes/no | _____ |

Other significant familial information that might impact your mental health treatment?

GOALS & TREATMENT PLANNING:

☆ What do you consider to be your personal strengths?

☆ What are some effective coping/self-care strategies you have learned? (exercise, journaling, etc..)

☆ What are your goals for therapy?

Please use this space to provide any other necessary information you would like to share for the purpose of treatment.

SOCIAL MEDIA CLAUSE

Per the AAMFT (American Association for Marriage and Family Therapists), the use of social media by way of Facebook, Instagram, Twitter, and other outlets, for therapists and their clientele to connect is prohibited for a minimum of 2 years post the termination of the therapeutic relationship and is then up to the therapist's discretion. This serves to protect the integrity of the therapeutic relationship.

LIMITS OF CONFIDENTIALITY

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

PARTNER B

Name: _____
 (Last) (First) (MI)

Birth Date: ____/____/____ **Age:** ____ **Gender:** Male Female _____
 Preferred Pronouns

Address: _____

 (City) (State) (Zip)

Marital Status:

Never Married Partnered Married Separated Divorced Widowed

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Children's Names and Ages: _____

Primary Phone: () - _____ **Emergency Phone:** () - _____

Voicemail? Yes No **Text?** Yes No **Emergency Person:** _____

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| _____ | _____ | _____ | _____ |

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| <u>Difficulty</u> | | <u>Family Member</u> |
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| Bipolar Disorder | yes/no | _____ |
| Anxiety Disorders | yes/no | _____ |
| Panic Attacks | yes/no | _____ |
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6. When the patient presents an imminent danger to self,
7. When the patient presents an imminent danger to others,
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BOTH PARTNERS REVIEW**DUTY TO WARN & PROTECT**

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When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

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Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

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Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

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Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

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Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and any ramifications should risk be reported.

Client signature (parent/guardian if under 16)

Date

CONSENT FOR TREATMENT

I, _____, **(client)** hereby consent to treatment by way of counseling with _____ **(counselor)** on this date & beyond. I understand that all efforts made by this counselor to assist in the meeting the goals set forth for treatment will be given with the best of intentions and out of the best interest of myself and all others involved in the counseling process. If at any time I feel that counseling services are not meeting my expectations, I can request a referral to an alternative provider that might better meet my goals for treatment without any bias or discrimination.

Additionally, each client may have a face sheet that is kept on file with Matters of the Heart Counseling, that is behind double lock, and includes your name, contact information, reason for treatment, and any safety plans created. This is in case of emergency should something happen to this counselor and their identified *In Case of Emergency* counseling partner will contact you to make alternative counseling plans.

I recognize that a copy of the **HIPAA Privacy Policies** for treatment has been made available online with the printable paperwork for me to print and keep for my own records.

Patient/Guardian Signature (if client is under 16)

Date

FINANCIAL AGREEMENT:

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance & your understanding of our payment policy.

Payment for service is due at the time services are rendered *unless* payment arrangements have been agreed upon *in advance*. We accept most credit cards, HSA's (Health Savings Accounts), cash, check and Venmo, though a small fee may be charged with credit transactions. Please note that any returned checks will have a service charge of \$25 per check to cover the counselor's bank fees.

SESSION ATTENDANCE:

It is important to understand that a session missed is also a session that cannot be booked for other clients, and time away from the therapist's home life. Your appointment time cannot be filled with other clientele *unless the appropriate notice has been given*. For this reason, we ask that you make every effort to provide at least a **24-hour advance notice** by your counselor's provided best contact (email/call/text).

We understand that crisis situations occur and circumstance can conflict with your ability to keep your appointment, and each counselor will consider the circumstances carefully. In most situations, when the appropriate amount of time has not been given to cancel, you may anticipate that **the full fee** will be applied to the card you choose to keep on file with this counselor.

This measure has been created out of necessity to ensure a mutual respect is established for one another's time.

PAYMENT:

*Insurance: While this practice does not currently accept Insurance, we can work with you and your insurance company or Health Savings Account to provide receipts and ICD-10 codes, which can be submitted to **some** plans for reimbursement. Please be aware that by submitting a superbill to your insurance, a diagnosis is required and will reflect on your permanent history which may impact insurance renewals or changes as it the diagnosis will be considered a "pre-existing condition."*

As counselors advance in their profession and gain licensure, specializations, etc, their rates may increase. While you are an active client, the rate with which you enter counseling, as posted in the space below, will remain the same, and will continue to be grandfathered in at the identified rate. (Unless otherwise discussed in writing with said therapist for any long-term clients). Once your file is closed, either through successful completion of treatment goals, termination of services, or a lapse in treatment exceeding 3 months, you will be required to complete NEW paperwork and will re-enter with the counselor at their present rate of services.

Each Provider at this Practice has created their own payment scale. The rates at this office range from \$50-\$250/Therapeutic Hour. For details about your counselor's rates, please visit our website at www.mattersoftheheartcounseling.org or contact your counselor directly for their current fees.

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As a professional courtesy, we acknowledge unforeseeable circumstances, and may extend grace for regular clients with whom have consistent attendance history. Should late cancelling and rescheduling appointments become a pattern, you will be given alternative referral options for comparable therapists in the area, as this might inhibit the quality of the therapeutic alliance.

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Sessions missed **without the required 24 hour notice** prior to scheduled session will be required to pay the **full fee for counseling services.** This will be automatically charged to the card you keep on file. It is important to note that most counselors have a waiting list of clients who would be able to coordinate their schedule to accept a cancelled appointment should an adequate notice be given.

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With **limited availability and high demand**, missed sessions without adequate cancellation time, has little tolerance in this practice. Should your card require being run more than 3 times for missed sessions, it will then be **mutually understood** that the therapeutic process is ineffective and therefore requires a referral outside of this practice.

This practice requires that ALL clients provide a valid credit/debit card to keep on file to assist in preventing missed sessions that are unable to be filled by other clients.

My Identified session fee is: _____/therapeutic hour (50-60 minutes)

Credit/Debit Card to keep on file for phone sessions, payment use, and potential no shows is:

Card # _____ Expiration: _____ CVV#: _____

Card billing zip code: _____ Name on the card: _____

Preferred Email address/cell number for receipt: _____

By signing below, I recognize that I have read and understand this therapist's expectation for my financial commitment and have read and agree to the Financial Agreement.

Signed: _____ Date: _____

Therapist Signature: _____ Date: _____

OFFICE BUILDING LIABILITY ADDENDUM:

After over 10 years in private practice, we are thrilled to be operating out of our own space, here at 243 Old Shackle Island Road in Hendersonville. With this home being over 100 years old, it is understood that there are some differences from most traditional office buildings to be mindful of when visiting our facility. We have fallen so in love with our Big Blue Farmhouse, we set out and found ANOTHER one at 214 North Main Street in Goodlettsville. It too is over a 100 years old and has been grandfathered in as a historic home, meaning, some of the things are less secure than a new build.

Regarding our Hendersonville Location:

Parking/Entering/Leaving: Please always use your turn signal when entering or leaving the facility from the main street. Parking spaces are provided in the back of the building. Please remain mindful to not block anyone in the driveway. Should there not be enough parking in the space provided, please consider parking to the side of the driveway, or the front of the building, cautiously. **Please do not utilize the pull through area** of the driveway as this area is small and was originally created for a horse and buggy to pick up and drop off, not your vehicle. (*see the small photo in the "puzzle room.")

Most of the time, our office has a low to moderate flow of client traffic throughout the day, however, evenings 4pm-7pm, are a high demand time for counseling, and parking can be limited.

Please consider carpooling when available and always be considerate of not blocking in vehicles. Also, remain considerate of the entry and exit of Old Shackle Island Road, especially during high traffic/rush hour times.

****We are working towards having the driveway paved with additional parking in front and on the side being made available. Until that time, please remain patient with our parking, and know we are working on a more effective system.**

BOTH FACILITIES:

Exterior Stairs: There are stairs located in the front of the building, and may require additional caution. Should you need to avoid stairs, we welcome your use of the back, staff entrance, that is off of the back patio.

Interior Stairs: Some of our offices and a bathroom are located upstairs. This stairway is more steep/narrow, and there is a handrail to use for safety purposes. Please use caution on these stairs. If you cannot use these stairs and your counselor is located upstairs, please inform your counselor and they can accommodate meeting with you in the conference space or possibly in one of the downstairs offices.

Interior Floors: Considering the age of the building, settling of the foundation, and other factors, the flooring throughout this building is uneven. This requires additional caution as you move about the building. Please familiarize yourself with your footing and use handrails for support where available.

Bathroom use: This building has 2 bathrooms, 1 located downstairs and 1 upstairs. The plumbing at both facilities is older and is very sensitive to anything non-sewer approved. Therefore, please do not flush ANY feminine products or other paper goods down the toilet, rather, utilize the provided trashcans.

Thank you for being on this journey with us, and as always, we hope that you feel as though this space is safe, warm, and inviting to walk through some of life’s most vulnerable trials you are facing. We value each of you and hope you feel that each time you enter this space. With that, we ask that you respect the space as if it was your own. Remembering that the expense of owning as opposed to renting is indeed bottomless with regards to maintenance and upkeep.

Should you have any concern about this document or working with our team at this facility, please contact Joanna at MattersoftheHeartTN@gmail.com or your respective counselor immediately so we may work together provide you with an alternative arrangement or referral to some local colleagues in the community, should there be the need.

Sincerely,



Joanna Dixon, LMFT, building owner
CEO | Matters of the Heart Founder
& the Matters of the Heart Team

By signing below, you are acknowledging that you have read the conditions of the building and the property at 243 New Shackle Island Road and waive the owners/counselors of any liability of injury that may occur while visiting this facility. You are also agreeing to be respectful and careful while on the premises’, as the age of the home lends it to greater risk of damage.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____