CLIENT INTAKE FORM

Therapy San Marcos

102 Whitetail Dr. Suite 100

San Marcos, Texas 786666

903-461-1837

jasmine@therapysanmarcos.com

Date: _____

CLIENT INFORMATION

Full Name: _____

Preferred Name: _____

Date of Birth: _____

Gender: _____

Address: _____

City, State, ZIP: _____

Phone (Home): _____

Phone (Mobile): _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

May we leave voicemail or text messages? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

Address: _____

REFERRAL SOURCE

How did you hear about our practice? ☐ Physician ☐ Friend/Family ☐ Website ☐ Insurance ☐ Other: _____

MENTAL HEALTH HISTORY

Reason for Seeking Therapy: _____

_____

Have you received mental health services before? ☐ Yes ☐ No

If yes, please provide details (e.g., therapist name, duration, type of therapy):

_____

Current or Past Diagnoses (if any): _____

Current Medications (include dosage and frequency): _____

_____

Any history of hospitalization for mental health? ☐ Yes ☐ No

If yes, please provide details: _____

Any history of substance use? ☐ Yes ☐ No

If yes, please provide details: _____

MEDICAL HISTORY

Primary Care Physician: _____

Phone: _____

Current Medical Conditions: _____

Allergies: _____

OTHER RELEVANT INFORMATION

Are there any current or past legal issues we should be aware of? ☐ Yes ☐ No

If yes, please provide details: _____

Are you currently experiencing thoughts of harming yourself or others? ☐ Yes ☐ No

If yes, please provide details: _____

CONSENT FOR TREATMENT

I, _____, consent to receive mental health services from [Therapy Practice Name]. I understand that:

- Therapy involves discussing personal and sensitive information, which will be kept confidential except as required by law (e.g., risk of harm, abuse reporting under Texas Family Code §261.101, or court orders).

- My therapist is a Licensed Professional Counselor-Associate (LPC-A) under supervision, as disclosed in the Supervisory Disclosure Statement.

- I have received and reviewed the Notice of Privacy Practices, outlining my rights under HIPAA and Texas Health and Safety Code §611.

- Treatment goals, methods, and progress will be discussed collaboratively with my therapist.

- There are no guarantees regarding the outcomes of therapy.

FEES AND POLICIES

Session Fee: $100 per 50-minute session

Cancellation Policy: 24-hour notice required, or a $100 fee will be charged

Payment Methods: cash, credit card, check

CLIENT ACKNOWLEDGMENT

By signing below, I confirm that the information provided is accurate to the best of my knowledge and that I consent to mental health services as described.

Client Signature: _____ Date: _____

(If client is a minor or legally incapacitated, a parent/guardian must sign)

Legal Representative Name: _____

Relationship to Client: _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____