Wishing Well Relationship Center, LLC

Dr. Ella Dixon, 1660 Akron Peninsula Rd., Suite 102, Akron, OH 44313, Phone: 330-414-8586. Email: drella@drelladixon.com

Individual Intake Forms

Part 2

Please complete and return:

Acknowledgement of Informed Consent for Assessment & Treatment and Office Policies
Client Registration Form
Individual Intake Form
Credit Card Authorization Form

Acknowledgement of Informed Consent for Assessment & Treatment and Office Policies

PLEASE INITIAL AND SIGN BELOW

I have reviewed, understand, and agree to the stated policies regarding consent.	
I have reviewed, understand, and agree to the stated policies regarding confidentiality.	
I have reviewed, understand, and agree to the stated policies regarding communication.	
I have reviewed, understand, and agree to the stated policies regarding emergencies.	
I have reviewed, understand, and agree to the stated policies regarding clinician fees.	
I have reviewed, understand, and agree to the stated policies regarding cancellation/no show/late arrival	
I have reviewed, understand, and agree to the stated policies regarding telephone calls.	
I have reviewed, understand, and agree to the stated policies regarding consultation.	
I have reviewed, understand, and agree to the stated policies regarding court testimony.	
I have reviewed, understand, and agree to the stated policies regarding coordination of treatment.	
☐You may inform my physician(s) ☐I decline to inform my physician *Release of Information must be completed	
I have reviewed, understand, and agree to the stated policies regarding records.	
I have reviewed, understand, and agree to the stated policies regarding termination.	
I have reviewed, understand, and agree to the stated policies regarding Therapist's incapacity or death.	
I have received and read a copy of the Notice of HIPPA Privacy Practices, Client Rights, and Payment Polices & Fee Agreement documents.	
I have reviewed, understand and agree to credit/debit card authorization.	

I have read and I understand the statements above. My signature indicates that I give free and full informed consent to receive services at Wishing Well Relationship Center under these conditions. I have raised any questions I might have about it with my clinician. I have received satisfactory responses and agree to comply with all items freely and without reservations.

Client's Signature:	Date:
Therapist's Signature:	Date:

Client Registration Form

Information Provided Here is Protected as Confidential

Date: _____/_____/_____

First Name: _____ Last Name: _____

Age: _____ DOB: ____/_____/_____ Ethnicity/Race_____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Occupation: _____

Home Phone: _____-_____-_____ Ok to leave a message? Yes ☐ No ☐

Cell Phone: _____-_____-_____ Ok to leave a message? Yes ☐ No ☐

Work Phone: _____-_____-_____ Ok to leave a message? Yes ☐ No ☐
(Optional)

Text Message OK to confirm appointments? Yes ☐ No ☐

Email: _____
Used to send office correspondence and other materials

Please List At Least One Emergency Contact Person Below:

Name: _____

Phone Number: _____

Relationship to You: _____

Referral – How did you hear about us?

☐ Psychology Today Website
☐ www.drelladixon.com Website
☐ Internet Search
☐ Other_____

Individual Intake Questionnaire

Please state the reason(s) you have come for counseling?

_____

_____

How long have these issues been of concern to you?

_____

What symptoms (emotional [sad], behavioral [angry outburst], physical [fatigue] are you experiencing as a result of these concerns/issues?

_____

_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weakness? _____

_____

How do you cope or deal with life stresses? _____

_____

List social and/or family support systems ("siblings, church, support group"):

_____

Current Functioning

Please **RATE** whether the following items are of concern, especially within the last 2 weeks, by using the following scale: 1 – Low 2 – Medium 3 – High NA (Not Apply)

	Job/financial Issues		Sexual Abuse
	Relationship Issues		Recovery Issues (alcohol/drug)
	Family Issues		Sleep (difficulty sleeping, sleeping too little or too much)
	Sexuality		Emotions (change quickly, control too much, feeling overwhelmed)
	Parenting Concerns		Self-control (anger, sexual impulses, food/weight issues)
	School		Anxiety (worry, fear, excessive guilt, restless, edgy)
	Recent Loss/grief		Depression (unhappiness, irritability, lack of motivation, grief, low energy)
	Emotional Abuse		Suicidal Thoughts (past attempts, plan)
	Physical Abuse		Thinking (disorganized, obsessive or, memory loss, trouble making decisions)

How would you rate your current physical health? (Please check)

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (Please circle)

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

Are you taking any medications? ☐No ☐ Yes If "Yes," list names, dosages and purposes:

Medication	Dosage	Purpose

Is there a history of emotional or psychiatric problems/hospitalizations for self or family members? ☐No ☐Yes
If "Yes," explain:

_____

Family Mental Health History

Please check	Yes	No	Family Member (mother, father, sibling, grandparents)
Alcohol/Substance Abuse	☐	☐	
Anxiety	☐	☐	
Depression	☐	☐	
Suicide Attempts	☐	☐	
Other:			

Have you ever had legal/court related problems? ☐No ☐ Yes If "Yes," please explain:

_____

Has drugs/alcohol ever caused you problems? ☐No ☐ Yes If "Yes," please explain:

_____

Have you ever felt like harming yourself or others? ☐No ☐ Yes If "Yes," please explain:

_____

Have you been a victim of physical/sexual Abuse? ☐No ☐ Yes If "Yes," please explain:

_____

Have you had any work or school related problems? ☐No ☐ Yes If "Yes," please explain:

_____

Education

Highest education attained_____ Area of study: _____

Military

Have you served in the armed forces? ☐Yes ☐ No

Branch:	When:

Spiritual/Religious

Do you have a religious/spiritual affiliation? ☐No ☐Yes If "Yes", please List

_____

Is this an important part of your life? ☐Yes ☐No

Family Background

Please list members of your immediate family

Name	Gender	Age	Relationship to you	Lives with you Yes	Lives with you No	Status of relationship 1 = Poor to 5 = Excellent
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Therapeutic History

Have you partner had any prior experience with counseling or drug/alcohol treatment, if applicable?

☐No ☐ Yes, If "Yes" Reason: _____

Was prior counseling helpful? ☐No ☐ Yes

Is there any other information you think that your therapist should know to help you?

_____

_____

_____

_____

_____

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Credit Card Authorization Agreement

For your convenience, you may keep a credit card authorization on file to pay for your sessions.

This information is confidential and will be securely stored in your clinical file and may be updated upon request at any time.

I hereby authorize Dr. Ella Dixon/Wishing Well Relationship Center, LLC, to keep my signature on file and to charge my credit/debit card account the full fee of $130.00 for psychotherapy services, and/or for non-emergency late cancellation/no show fee (less than 24 hour notice), **when applicable.**

If any check is returned unpaid your credit/debit card will be charged the appointment fee along with an additional $35 dollar returned check fee. I have read, agreed, and understand the Payment Policy and Fee Agreement.

I understand that if I decide to terminate any of the services and my account is paid in full, I may withdraw the authorization to charge my credit/debit card if I communicate revocation of authorization in writing, email, or complete a revocation form in office to Dr. Ella Dixon/Wishing Well Relationship Center, LLC.

As a courtesy, I offer my clients the option for their session fees to be billed directly to their credit card.

Please check: ☐Monthly ☐Each Session

Please complete all information below.

Credit Card Information:

Name on Card:_____

Card Type: ☐Discover ☐Visa ☐MasterCard ☐American Express ☐Debit/Check Card

Card Number:_____

Expiration Date:_____ CVS Code_____
(The 3 digit code on back of card)

Billing Address: _____

City: _____ State: _____ Zip code: _____

_____ _____ _____
Cardholder Signature Printed Name Today's Date

**Credit Cards are processed through Square Register.*