Whole Health KC **www.wholehealthkc.com**
Members of KC Well Co.
3216 Gillham Plaza, Suite 210
Kansas City, MO 64109

INTAKE FORM

CLIENT INFO

Name _____ Date _____

Address _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Gender _____

Phone _____ Email _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Who referred you to us or how did you hear about us? _____

Religious/spiritual history: _____

Number, age, and gender of children _____

Marital/relationship history _____

Level of education _____

HEALTH & WELLNESS BACKGROUND

Primary Care Physician _____

Psychiatrist _____

Do you have any significant physical or mental health diagnoses? If so, what? _____

_____

Are you taking any medications? _____

Are you taking any supplements (including CBD)? _____

How do you grade your:

Physical health?

☐ excellent ☐ good ☐ fair ☐ poor ☐ getting worse ☐ getting better

Emotional/Mental health?

☐ excellent ☐ good ☐ fair ☐ poor ☐ getting worse ☐ getting better

Mental health treatment history (please include previous treatment history and diagnoses):

_____

History of Hospitalizations?_____

Family history of mental health or emotional challenges _____

_____

Number of siblings, including yourself _____ Your birth order _____

Other significant family information _____

What role do animals play in your life? _____

Have you experienced domestic violence?

☐ physical ☐ sexual ☐ financial ☐ threats ☐ intimidation ☐ emotional ☐ isolation

Is there anything else you wish to tell me that you feel relates to your visit? _____

_____

_____

_____

What brings you in to psychotherapy? _____

_____

How long have you had the problem(s)? _____

What other ways have you tried to deal with this problem? _____

_____

If you have a history of any of the following symptoms, please mark them "HX." If you are experiencing any of these presently, please label them, "PR."

_____ High Blood Pressure
_____ Low Blood Pressure
_____ Dizziness or fainting
_____ Ulcers
_____ Indigestion
_____ Irritable Bowel (IBS)
_____ Pounding/Racing Heart
_____ Chest pain
_____ Shortness of breath
_____ Fearfulness
_____ Anxiety
_____ Panic attacks

_____ Nightmares
_____ Vivid dreams
_____ Difficulty sleeping
_____ Migraine headaches
_____ Tension headaches
_____ Changes in appetite
_____ Weight gain/loss
_____ Fatigue/low energy
_____ Prolonged sadness
_____ Depression
_____ Guilt
_____ Feelings of inadequacy

_____ Heavy drinking
_____ Drug use or abuse
_____ Diabetes
_____ Hypoglycemia
_____ Hypothyroidism
_____ Colitis
_____ Suicidal thoughts
_____ Suicide attempt(s)
_____ Unstable job pattern
_____ Job unhappiness
_____ Lack sense of meaning
_____ Lack sense of purpose

Please check the items you would like to address in therapy:

Symptom-Related Concerns
____ Anxiety
____ Depression
____ Unhappy
____ Lack of confidence
____ Grief/loss
____ Anger
____ Numbness
____ Develop coping skills

Health Concerns
____ Medical/Physical illness
____ Difficulty sleeping
____ Nightmares
____ Exhaustion
____ Drug-related concerns
____ Alcohol-related concerns
____ Eating or weight-related

Personal Goals
____ Develop clearer sense of identity
____ Concerns related to spirituality
____ Deepen inner work
____ Dreamwork
____ Meaning & purpose
____ Develop self-awareness
____ Develop assertiveness

Social Relationships
____ Social anxiety
____ Shy around others
____ Difficulty making friends
____ Isolation/Loneliness
____ Difficulty relating
____ Conflict with others

Career/work
____ Career choice
____ Financial concerns
____ Difficulties at work
____ Problems making decisions
____ Personality conflicts
____ Overwork/stress
____ Life/Work balance

Spouse/Significant Other
____ Marital Concerns
____ Difficulty relating
____ Conflict
____ Verbal abuse
____ Physical abuse
____ Sexual concerns
____ Financial stress

What are your goals for therapy? _____

_____

_____

CONSENT FOR TREATMENT
Your signature below indicates that you consent to the provision of psychological or mental health services for yourself and/or dependent named below. It also serves as an acknowledgment that you have received or been apprised of how to secure the HIPAA notice form.

Client Name _____

Signature (Parent/Guardian if patient is a minor) _____

Date _____

Relationship to Client _____

CONSENT FOR CONTACT
Your signature below indicates that you consent to our team members contacting you to conduct business related to therapy, including scheduling or other issues that may arise.

Methods of Contact
_____ Cell phone/text messaging
_____ Email
_____ Home phone

Signature & Date
(Parent/Guardian if patient is a minor) _____

FINANCIAL COMMITMENT
The following guidelines have been established for payment of financial obligations for services rendered in this office. All clients are self-pay clients, meaning that no insurance is accepted. During the first session, the therapist and client will

set an agreed upon fee for future sessions. The standard rate is $125 per session, though a sliding scale is offered for those who need a lesser amount to meet budgetary constraints, with a minimum of $80 per session.

PLEASE BE AWARE THAT SESSIONS MUST BE CANCELLED AT LEAST 24-HOURS IN ADVANCE. THE NORMAL, AGREED UPON FEE WILL BE CHARGED FOR NO-SHOWS AND LATE CANCELLATIONS. However, exceptions will be made for adverse road conditions or other unforeseeable emergencies. If you are sick and there is a chance you may not make your session, please give your therapist as much warning as possible.

Signature & Date
(Parent/Guardian if patient is a minor)

_____