



MARTI WIBBELS, M.S., LMHC, LPC, PLLC

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern: \_\_\_\_\_

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties. \_\_\_\_\_

What do you hope to accomplish in counseling? \_\_\_\_\_

What kind of obstacles could get in the way? \_\_\_\_\_

Have you been in therapy before or received any prior professional assistance for your concerns? Y / N

If so, please give dates of treatments and results: \_\_\_\_\_

**Behavioral– circle any of the following behaviors that apply to you:**

- |                  |                     |                   |                       |                            |
|------------------|---------------------|-------------------|-----------------------|----------------------------|
| Overeating       | Suicidal attempts   | Can't keep a job  | Taking drugs          | Compulsions                |
| Insomnia         | Vomiting            | Smoking           | Taking too many risks | Odd behavior               |
| Withdrawal       | Lack of motivation  | Drinking too much | Nervous ties          | Eating problems            |
| Working too hard | Procrastination     | Sleep disturbance | Crying                | Impulsive reactions        |
| Phobic avoidance | Outbursts of temper | Loss of control   | Aggressive behavior   | Concentration difficulties |

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Are there any specific behaviors, actions, habits that you would like to change? \_\_\_\_\_

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**Emotional – circle any of the following feelings that apply to you:**

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Bitter	Others:

**Physical – circle any of the following symptoms that apply to you:**

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

**Spiritual Factors:**

Religious background \_\_\_\_\_ Present affiliation, if any \_\_\_\_\_

Is this an important part of your life? \_\_\_\_\_ Do you have any current concerns in this area? Y / N

If so, please describe: \_\_\_\_\_

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**Biological Factors:**

Do you have any current concerns about your physical health? Please specify: \_\_\_\_\_

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Have you had any surgery in the past three years? If so, please specify: \_\_\_\_\_

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter): \_\_\_\_\_

Do you get regular exercise? Y / N If so, what type and how often? \_\_\_\_\_

**Check any of the following that apply to you:**

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

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Are there any other mental, emotional or spiritual concerns you want to address in therapy? \_\_\_\_\_

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**THERAPY AGREEMENT**

I, \_\_\_\_\_, have applied for counseling and/or assessment services at Marti Wibbels, LMHC, LPC, PLLC) for myself and the following person(s) for whom I am legally responsible.

\_\_\_\_\_  
\_\_\_\_\_

I understand that, due to confidentiality, counseling sessions may not be recorded in any form.

I am responsible for any indebtedness incurred as a result of services rendered to me or those under my guardianship by this therapy or assessments.

I understand that if, during the course of treatment, the counselor determines that a threat of physical harm (including child or elder abuse) to the client or to another person is imminent, by law, the appropriate authorities must be notified, in accordance with Florida or Tennessee statutes.

I further agree to indemnify and hold harmless Marti Wibbels, PLLC, its agents, volunteers or employees from any claim for damages of any nature arising out of or allegedly due to any counseling, instruction or advice rendered by personnel of Marti Wibbels, PLLC, or out of any activity related thereto. I accept full responsibility for any decisions I make regarding my life.

**I have read the above information carefully, understand its contents, and agree, under these conditions, to receive services for myself and/or anyone herein designated.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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**P A Y M E N T   A G R E E M E N T**

Client Responsibilities

Payment is due at the time service is rendered. Please pay by cash, check or credit card. If paying by check, please make check payable to Marti Wibbels.

The fee is \$150.00 for a 45 to 50-minute session, or \$225.00 for a 75-minute session.

Sessions of three (3) or more people are billed at the rate of \$300 for a 45 to 50 minute session.

Cancellation of a session must be made at least 24 hours prior to the scheduled time or you will be billed for the missed session.

For reasons of confidentiality, we do not make appointment reminder calls. You are responsible for keeping your appointments.

An invoice may be sent to your home for any outstanding balance.

The undersigned certifies that he/she has read the above information carefully, understands its contents, and agrees to comply with the terms of payment as provided above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

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**CREDIT CARD AUTHORIZATION FORM**

Date: \_\_\_\_\_

This is to authorize payment for \_\_\_\_\_ for counseling sessions at the rate of \$ \_\_\_\_\_ per 50-minute session. I understand that my credit card will be charged on the day of my scheduled appointment, prior to the session in order to maximize my scheduled time. I authorize \_\_\_\_\_ (number) of sessions to be charged with this card.

Please initial the following:

\_\_\_\_\_ I understand that appointments require a 24-hour cancellation notice. Because my appointment time is set aside exclusively for me, I understand that no-show appointments will be charged in full if the appointment is not cancelled or rescheduled at least 24-hours prior to the appointment.

\_\_\_\_\_ If credit card on file is not approved for payment, I understand that alternate payment arrangements must be made within 5 business days after I am notified of a declined credit card payment.

**Credit Card Type:** [  ] VISA [  ] MC [  ] AMEX [  ] DISC

**Credit Card Number:**

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**CCV:**  **Exp date:**  /

**Cardholder's name as it appears on the credit card:**

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**Cardholder's billing address:**

Street:		
City:	State:	Zip Code:

**Cardholder's phone number:**

**Cardholder's Signature:**

\_\_\_\_\_