



Mindy Berry Counseling  
How are you feeling?

**Client Intake/Questionnaire:**

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

How did you hear about me? \_\_\_\_\_

**General Information:**

Name: \_\_\_\_\_

Client is:  Self  Couple  Family  Minor (under 15)

Gender:  M  F  Transgender  Other

Address: \_\_\_\_\_

Phone Numbers: (day) \_\_\_\_\_ (night) \_\_\_\_\_

May I leave a message? Y N

Email: \_\_\_\_\_

What is the best way to contact you? \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Years Married: \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Partner's Age: \_\_\_\_\_

Children: Y N

Names & Ages: \_\_\_\_\_

Name & phone # of emergency contact person: \_\_\_\_\_

**Parent/Guardian Information (if client is under 15):**

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address (if different than above):  
\_\_\_\_\_  
\_\_\_\_\_



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Phone #: \_\_\_\_\_

Can you be contacted at this number? \_\_\_\_ Yes \_\_\_\_ No

Email address: \_\_\_\_\_

Can you be contacted by email? \_\_\_\_ Yes \_\_\_\_ No

**Permission for Treatment**

I am presenting myself (or my child) for diagnosis and treatment. I voluntarily consent to the rendering of counseling services provided by Mindy Berry Counseling, LLC. I acknowledge no guarantees have been made to me as to the effect of treatment on my (or my child's) condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

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**Client/Parent/Guardian Signature**

**Date**

Description of Presenting Problem:

In your own words, what would you like to work on in counseling?

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How long have you been struggling with these issues?

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What are your goals for therapy?

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Have you had counseling before? Y N

How recent? \_\_\_\_\_

Mental Health Inpatient Hospitalizations? Y N

Please circle any of the following that apply to you:

- Overeat/eating disorder      Suicide thoughts/attempts      Work stress/unemployment  
Insomnia      Vomiting      Take too many risks      Odd behavior      Withdrawal  
Drink too much      Compulsions      Difficulty concentrating      Aggressive behavior  
Procrastination      Sleep disturbance      Crying often      Impulsivity      Avoidance  
Anger outbursts      Loss of control      Laziness      Take drugs

Others: \_\_\_\_\_

Are there any specific behaviors or habits you would like to change?

\_\_\_\_\_

List three emotions/feelings/sensations you most often experience:

\_\_\_\_\_

How would you describe yourself?

\_\_\_\_\_

How would others describe you?

\_\_\_\_\_

How would you describe growing up/your upbringing?

\_\_\_\_\_

Who/what do you go to for support in your life?

\_\_\_\_\_



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Please list any medications you are taking, their dosages, and who prescribes them for you:

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Date of your last physical: \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ Drinks per day: \_\_\_\_\_ Drinks per week: \_\_\_\_\_

Please list any drugs that you have taken or are taking other than those required for medical reasons:

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Does alcohol, drug, or other mental health issues run in your family history?

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If answered above yes, please list family members and what they struggle with:

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Please list any major illnesses or medical issues that you have had/are having:

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Is there anything else you would like to share/want your counselor to know about you?

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## Credit Card Authorization Form

I, \_\_\_\_\_, hereby authorize Mindy Berry, MA, LPCC, to charge my account according to the following schedule:

**Licensed Therapist Rate:** For each 45-minute counseling session

- Zelle, Venmo, or Cash: \$90 Individual \$100 Couples
- Credit Card: \$100 Individual \$110 Couples
- \$90 for each No Call/No Show
- \$90 for each late cancel. Cancellation policy is no less than 24 hours notice.
- 90-minute sessions may be offered at the discretion of the therapist.

Zelle (mindyberycounseling@gmail.com)     Venmo @Mindy\_Berry

Cash     VISA     Mastercard     American Express

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_    CVV: \_\_\_\_

**Credit Card Billing Address:**

Name on card: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_    State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email: \_\_\_\_\_

***By signing below, I authorize the charges specified above.***

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**