

Finding Balance, PLLC

Jennifer Moynihan Wynn, MS, LMFT

Individual & Couples Therapy

Phone: (919) 926-8057 ~ Email: Jennifer@findingbalancenc.net ~ Web: www.findingbalancenc.com

Welcome! I am happy you have made the decision to begin your therapeutic experience and I look forward to being of service to you. I have compiled a welcome packet with intake forms for you to fill out at your leisure. Please fill them out and return them to me, or bring them with you to our first scheduled appointment.

I am honored to be a part of your journey and hope you find my services and guidance valuable.

Warm Regards,

Jennifer Moynihan Wynn

Jennifer Moynihan Wynn, MS, LMFT

Licensed Marriage and Family Therapist

Certified Gottman Therapist

(919) 926-8057

jennifer@findingbalancenc.net

www.findingbalancenc.com

1300 SE Maynard Rd

Suite 203

Cary, NC, 27511

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Contact information:

Name: _____ Birthday: _____

Spouse/Partner/Significant other: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Home Address/State/Zip: _____

Emergency Contact Name/ Relationship: _____

Emergency Contact Phone: _____

Referral Source: Google Psychology Today Facebook Friend Gottman Institute

Other Professional (who?) _____ Other: _____

Would you like me to inform your Primary Care provider or other health professional of your treatment? _____ (Initial) **Consent** _____ (initial) **Refuse**

If so, please provide name and contact information: _____

How may I contact you?

___ Home Phone ___ Cell Phone (May I leave a voice mail?) Y N

___ Email ___ Text Message

What is your preferred method of contact?

___ Home Phone ___ Cell Phone ___ Email

_____(Initial) **I understand that electronic communication such as text messaging and email may not a secure form of contact, and that if I choose to communicate with my therapist by using these means that I do so at my own risk.**

Client / Parent Signature: _____ Date: _____

Printed Name : _____

Client / Parent Signature: _____ Date: _____

Printed Name : _____

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Rights & Responsibilities Services Contract

Please keep this contract for your records

I value professionalism, quality services, and respectful attitude towards you as my client. I extend this courtesy to you by outlining my policies for promoting a smooth working relationship. Should you have any questions regarding any of the contents put forth below, please do not hesitate for clarification.

Standard Policies:

- My standard fee for therapy is \$125 per 45-60 minute session. If we agree to longer or shorter sessions, you will be charged accordingly. Payment in full is expected at the end of each session.
- Because I reserve this time for you, it is expected and that you will give **twenty-four hours' notice** if you need to cancel or reschedule an appointment. When your provider does not receive twenty-four hours' notice, **you will be charged a late cancellation fee (\$85)**, unless there is an emergency that prevented you from contacting your provider. Late cancellation fees are not covered by insurance. **This fee is waived or reduced at the provider's discretion and is determined on a case by case basis.**
- **No-show fees** are charged for appointments broken, with no communication with the therapist, and these are equivalent to a regular session fee (\$125). **No- show and late cancellation fees are NOT covered by insurance.**
- If you are late for a session, the time of your session may be shortened, but you will be required to pay for a full session. For individuals who haven't called and are late to an appointment, the regular fee will still be expected for the time I reserved for you. If an emergency occurs that causes this, we can discuss the exception.
- **Phone calls:** Phone calls made to the therapist will be **time-limited to fifteen minutes**. The therapist will **prorate her full session fee in fifteen minute increments** for any phone call lasting over fifteen minutes, up to a full session fee. The therapist will return phone calls within 24 hours and will not answer phone calls after 9:00pm.

After- hours or Crisis services may be contacted by calling Alliance Behavioral Healthcare at 1-800-510-9132

- There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances, phone calls lasting over 15 minutes, and missed appointments. These fees will be prorated based on time spent up to a full session fee (\$125). There is an increased fee for court appearances, up to \$300 per hour.
- Therapists have the right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.
- Payment is due at the time of service unless otherwise arranged. When special circumstances arise that make payment difficult, please discuss them with your provider.
- Payment for services is accepted in cash, credit cards and checks. **A fee of \$30 will be charged for returned checks.**
- Honesty, openness, active participation, and willingness to change are required for the services to be effective.
- Services last as long as you and your provider agree they are necessary.
- Completion of tasks as discussed and decided in session are an important part of treatment and you are encouraged to comply with them for services to be effective. This also applies for additional referrals made as deemed necessary (i.e., individual therapy, substance abuse treatment, etc.)

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Couples Therapy: Unique Concepts and Limitations

Insurance and Couples Therapy

While Jennifer Moynihan Wynn is an in-network provider with Blue Cross and Blue Shield, she will **not bill insurance for couple's therapy** for the following reasons:

- Couples therapy is not a provided benefit under most insurance plans, because insurance plans require **medical necessity** for treatment. This means that to use health benefits for treatment, you need a **diagnosable mental health disorder** and your therapist needs to prove that your disorder is **causing significant impairment in your life on a day-to-day basis**. While you may have anxiety, a depressive disorder, or other mental health challenges, the focus of treatment in couple's therapy is the treatment of your relationship dynamic rather than on your mental health condition, and the insurance company does not see communication and relationship challenges as medically necessary. You would not expect your insurance to cover cosmetic enhancements, and couple's therapy is seen by the insurance company in a similar light. It may improve your quality of life, but it is not considered medically necessary.
- It is possible that if you call your insurance company and ask if they cover couple's therapy, they may say yes, but it does not guarantee coverage of services, even if you obtain an authorization number. What the insurance company is referencing in saying "yes" to couple's counseling is that they cover a procedure code that allows a person's family member or significant other to be present in therapy. The focus of counseling is not on your relationship, but rather the treatment of a **diagnosable mental health condition**. They consider your partner as a support in the treatment of your mental health condition, not as a person also receiving treatment for relationship challenges. If you wish to call your insurance company to inquire about couple's therapy coverage, you need to be specific and ask about covering the diagnostic code **Z63.0 Relationship distress with Spouse or Intimate partner** for procedure code 90847.
- Labeling one person as the "identified patient" can unbalance the treatment and run the risk of pathologizing a partner. Couple's issues are best addressed from a framework of working through a relationship challenge together. Even a subtle notion of one person's mental health problem being the focus of treatment can become problematic in couple's therapy.
- I am dedicated to providing ethical treatment, and taking advantage of a medical diagnosis to justify treatment of a relationship issue is misleading and not an ethical practice.

Couples Therapy Unique Confidentiality Limitations

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be a couple or a family with numerous persons participating within the therapy services. **This section is intended to inform you that when I agree to work with a family or a couple, I consider that family or couple (the treatment unit) to be the patient (client).**

- If there is a request for the treatment records of the family or the couple, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. The therapist will not make confidential disclosures without the full written consent of the parties present.
- If my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the treatment unit.
- During the course of my work with a family or a couple, I may see a smaller part of the treatment unit (e.g., an individual or more participating family members) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated.
- These sessions are confidential in the sense that I will not release any confidential information to a third party unless required by law or I have your written authorization. **However, when providing family or couples therapy, I may need to share information learned in an individual, separate session with the entire treatment unit - that is, the family or the couple, if I am to effectively serve the family unit being treated.**

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- I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure.
- If you feel it necessary to talk about matters that you absolutely want to be shared with no one, it is recommended that you consult with a therapist who can treat you individually. The therapist can make recommendations to individual therapists if needed.
- This policy allows me to avoid a possible conflict of interest to arise, where an individual's interests may not be consistent with the interests of the unit being treated. If necessary disclosure is not agreed upon, the therapist may need to terminate treatment, and this policy is in place to avoid a need for such termination

Confidentiality Policy

You should be aware that there are several situations in which your provider is required by law to reveal information obtained during provision of services to other persons or agencies **WITHOUT YOUR PERMISSION**. Also, your provider is NOT required to inform you of her actions in this regard. These situations are as follow:

- If you threaten bodily harm or death to another person, your provider is required by law to inform the law enforcement agencies.
- If you threaten bodily harm or death to yourself, your provider will inform law enforcement agencies and others (such as spouse / partner, emergency contact person, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
- If a court of law issues a legitimate subpoena, your provider is required by law to provide the information described in the subpoena.
- If you reveal information relative to child abuse and / or neglect, your provider is required by law to report this to the appropriate authorities.
- If you are in treatment or being assessed by order of a court of law, the results of the treatment or evaluation ordered must be revealed to the court.

Social Media and Electronic Communication Policy:

There are possible risks associated with communicating with the therapist via electronic methods (e.g. text messaging, email, social media, video conferencing), including:

- There is no guarantee that these messages can be kept confidential. Messages can be easily redistributed, forwarded, etc without knowledge or intention by the sender or recipient. The therapist is obligated not to forward or share any information without your written consent, but the therapist cannot guarantee your privacy if you choose to forward said communication. The therapist is not responsible for any breach of confidentiality that has been caused by the client.
- While I make every reasonable effort to protect your privacy on my end (encrypted emails, HIPPA signed business agreement with email provider), I cannot guarantee that you have the same level of encryption on your computer.
- Your employer or school email can be accessed at any time by these entities. If you choose to communicate with me via email, I encourage you to use a personal email from your home computer. However, even email sent from a privately owned computer may leave a "footprint" on the way from a sender's "outbox" to a recipients "inbox". Therefore, deleted messages may not be fully deleted. These messages have the potential to be accessed by law enforcement, ISP technicians, and hackers. Therefore, if you are communicating with me via email, it is advised that you do not discuss clinical issues, but rather use it for appointment reminders, rescheduling, etc.

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- The therapist uses Google Voice for telephone communication and voice mail transcription. **It is not advised to discuss clinical issues over voicemail or text**, as the therapist cannot guarantee security. It is advised that voicemail and text messages are used only as a request for call back or for scheduling issues.
- If you prefer to communicate with me via text message or email regarding scheduling or cancellations, I will do so. While I try to return messages in a timely manner (generally within 24 hours), I cannot guarantee an immediate response. This method of contact is not to be used for clinical assistance or in case of an emergency. **In the case of an emergency after hours, call 911 or Alliance Behavioral Healthcare at (800) 510-9132. Do not use text messaging or email for emergency situations.**
- I am ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. Any communication via electronic means is subject to be included in your medical record. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply.
- If we choose to use video conferencing for sessions, please note that no video conferencing software can guarantee security. I use dedicated telemedicine software for video conferencing (Vsee) to provide the best security possible. The therapist ensures security on her end by holding sessions in her office, but cannot be held responsible if the location in which you choose to have your session is not secure.
- While Finding Balance, PLLC has a social media presence (Facebook, Twitter, Pinterest), this is not an intended platform to discuss individual clinical issues or concerns. If the client chooses to interact with Finding Balance, PLLC in this manner (e.g. following, liking), the client agrees not to post confidential information or request information regarding appointments on social media platforms. The therapist is not responsible for any breach of confidentiality that has been caused by the client.
- The therapist will not “friend” or accept any friend requests from current or former clients on any social networking site. Adding clients as friends can compromise confidentiality, and may blur professional boundaries of the therapeutic relationship.

Limitations of the Service Provision Contract:

- Providers are not physicians and cannot prescribe medication or give recommendations about physical problems. Nevertheless, depending on the nature of the presenting concerns, providers might require clients to consult with a physician before proceeding with treatment.
- Providers cannot guarantee that each person’s goals in therapy will be met completely.
- Seeking to resolve issues between family members and other persons can lead to discomfort, as well as relationship changes that may not be originally intended.

Your Rights:

- You have the right to ask questions about any procedure or intervention used during service provision.
- You have the right to decide NOT to receive services from our practice and may ask for a referral to another qualified professional whose services you might prefer.
- You have the right to end services at any time without any moral, legal, or financial obligations other than those already accrued and agreed upon.

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Supervision and Professional Involvement:

Jennifer Moynihan Wynn, MS, LMFT is concerned with providing the best services possible. To ensure the quality of services, supervision of cases is done through verbal consultations of the sessions with a supervisor and associate colleagues as needed. When applicable (and with your written permission), this process may include sharing recordings of sessions. All information is confidential and is only utilized in supervision other professional endeavors (while maintaining anonymity as much as possible).

While I have taken training in the Gottman Method of couples' therapy, I am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

Scope of Professional Services:

The professional services provided by Jennifer Moynihan Wynn, MS, LMFT are treatment oriented in nature. **The services are not forensics oriented. We do not provide evaluation services that lead to professional opinions regarding child custody, parent visitation nor employment disability.** With written permission by the client and at the request of the client or a third party, we can offer case working impressions and related treatment recommendations that may be informative regarding various family, parenting and/or employment functioning. This however, draws from a treatment based relationship in contrast to a separate professional relationship and contract, which requires non-treatment objectivity to formulate a forensics' based professional opinion. **Jennifer Moynihan Wynn will not willingly agree to appear or testify in court for any reason.** If she is subpoenaed, she has the right to charge up to \$300 per hour for her time, and makes no guarantee that her presence or testimony will be beneficial or yield desired results.

Emergency Policy:

In the event of an emergency, **call Alliance Behavioral Healthcare at 1-800-510-9132.** You may also call 911 or proceed to an emergency room for immediate intervention. You may give the attendant your provider's contact information and also advise your provider of the situation by the next business day.

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Consents and Agreements (Initial):

1. _____ As a client of Jennifer Moynihan Wynn, MS, LMFT, I understand my rights and responsibilities and consent to be the recipient of therapeutic services under the assigned provider. Parent signature is required for children under 18 years of age.
2. _____ I understand the limits to confidentiality as outlined above. I understand the special considerations regarding confidentiality in couples and family therapy.
3. _____ I authorize my spouse/partner/significant other to be a participant in my therapy sessions (if applicable).
4. _____ I authorize my insurance benefits to be paid directly to the Therapist (in-network claims). I authorize the Therapist to release any information required to process insurance claims (if applicable).
5. _____ I understand that Couples Therapy is not a covered service under insurance plans and I willingly agree to be provided this service at my own expense (if applicable).
6. _____ I understand that I am financially responsible for my bill and any services not covered by insurance. If I cancel an appointment with less than 24 hours notice, there is a late cancellation fee of \$85. If an appointment is missed without notice to the therapist, I understand that I will be billed for the cost of a full session fee (\$125). I understand that late cancellation and no show fees are not covered by insurance and I will be billed these fees unless other arrangements have been made with the therapist, which is considered on a case by case basis.
7. _____ I have read and understand the social media and electronic communication policy.
8. _____ I understand that the services provided by Jennifer Moynihan Wynn, MS, LMFT are treatment oriented and **NOT** forensic oriented in nature. I understand that Mrs. Wynn cannot provide evaluation services that lead to professional opinions regarding child custody, parent visitation nor employment disability.
9. _____ I understand that Jennifer Moynihan Wynn will not willingly agree to appear or testify as an expert witness in court for any reason. If she is subpoenaed, she has the right to charge up to \$300 per hour for her time, and makes no guarantee that her presence or testimony will be beneficial or yield desired results.
10. _____ I have received Finding Balance, PLLC's notice of HIPAA privacy practices.
11. _____ I consent to receive postal mail in a confidential envelope to the address listed on my contact information sheet for purposes of discharge from services and notification of outstanding payment balances, if needed.

~~~~~  
 Client / Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name : \_\_\_\_\_

Client / Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name : \_\_\_\_\_



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**CREDIT CARD AUTHORIZATION**

I, \_\_\_\_\_, understand that if I choose to use a credit card to pay for clinical services, that a card will be kept on file through Finding Balance, PLLC's merchant services account (Square). I authorize Jennifer Moynihan Wynn, MS, LMFT to charge my credit/debit card for professional services as follows: Please initial:

- \_\_\_\_\_ Routine charges for clinical services
- \_\_\_\_\_ I understand and agree that my card will be charged a fee should any of the following arise (emergencies and exceptions considered on a case by case basis):
  - Cancellations with less than 24 hours notice (\$85 late cancellation fee)
  - Appointments I miss without notice (no-shows) (\$125 full session fee)
  - Insurance refusal to pay for services
- \_\_\_\_\_ I will not dispute charges ("charge back") for sessions I have received, non-payment by insurance company, or appointments I missed according to the above policy
- \_\_\_\_\_ I understand this form is valid for the length of treatment unless I cancel the authorization in writing

***Charges will appear on your credit card statement as Finding Balance, PLLC***

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Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ Identified Gender: \_\_\_\_\_ Relationship status: \_\_\_\_\_

*The following information provided below is designed to help me obtain a global understanding of your mental health. Please feel free to answer as much or as little as you are comfortable, as we will discuss in greater detail during our first meeting.*

**Presenting Problems**

What are your immediate needs? How long have you had problems with these? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment History**

Have you ever been in therapy for mental health or substance abuse concerns before? (If so, please describe experience- where, when, how long, with whom, etc): \_\_\_\_\_  
\_\_\_\_\_

Have you ever been admitted to a psychiatric hospital for mental health or substance abuse?  
\_\_\_\_\_

What are your expectations about therapy? What do you hope to get out of therapy? \_\_\_\_\_  
\_\_\_\_\_

What are your strengths? \_\_\_\_\_  
\_\_\_\_\_

What are your areas for growth? \_\_\_\_\_  
\_\_\_\_\_

**Safety**

Have you ever intentionally hurt yourself (e.g. cutting, burning)? Yes No

When was your most recent episode? \_\_\_\_\_

Have you ever attempted suicide or had a plan to physically harm yourself? Yes No

When was your most recent episode? \_\_\_\_\_

Are you currently having any suicidal thoughts or thoughts to physically harm yourself? Yes No

Do you currently have a plan to commit suicide? \_\_\_\_\_

Are you a survivor of emotional, physical, sexual abuse, neglect, trauma, war, terrorism?

Please explain: \_\_\_\_\_  
\_\_\_\_\_

**If you are experiencing a life threatening emergency, please call 911. For for a non-life threatening mental health emergency call Alliance Behavioral Healthcare at 1(800)-510-9132**

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Have you been having problems with any of the following areas **for at least the past two weeks?**

- Anxiety
- Depression
- Uncontrollable crying
- Panic Attacks
- Feeling Suicidal
- Feeling Hopeless
- Feeling worthless
- Feeling guilty
- Feeling tired all of the time
- Irritability
- Anger outbursts
- Feeling like I want to hurt someone
- Nightmares
- Hyperactivity
- Impulsivity
- Not knowing who I am
- Uncontrollable spending
- Increased energy
- Difficulty with people
- Difficulties in my relationship
- Feeling disconnected from my body
- Hearing voices
- Feeling like I am being watched
- Hallucinations
- Sleeping more than usual
- Unable to fall asleep
- Unable to stay asleep
- Difficulty Concentrating
- Extreme fluctuations in mood
- Difficulty keeping relationships
- Sexual problems
- Low Self-Esteem
- Problems with Alcohol
- Problems with Drugs
- Injuring myself (e.g cutting, burning)
- Problems with body image
- Binge eating or Purging
- Running away from home
- Lying
- Property destruction
- Problems at work
- Problems at school
- Problems following rules
- Decreased motivation
- Obsessions/Compulsions
- Grief
- Social Isolation
- Significant weight gain/loss
- Abuse/trauma
- Problems with memory
- Feeling always on guard/alert
- Avoiding situations, people, places
- Phobias
- Physical health problems

Please describe any additional problems not listed above: \_\_\_\_\_

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**Health**

How would you rate your current physical health?

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Do you have any health problems? (Current or previous): \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

How many times per week do you generally exercise? \_\_\_\_\_

Please list any difficulties you experience with your appetite or eating patterns: \_\_\_\_\_

**Chemical Use**

Do you use recreational drugs? (if Yes, please list and frequency): \_\_\_\_\_

Do you drink alcohol? (type and frequency): \_\_\_\_\_

Have you ever been criticized about your use of alcohol or drugs? \_\_\_\_\_

Have you ever felt the need to cut back on your use? \_\_\_\_\_

Have you ever felt guilty about your use of drugs or alcohol? \_\_\_\_\_

Have you ever had any significant consequences or impairments as a result of your use? \_\_\_\_\_

**Social Support**

Who lives in your home with you? \_\_\_\_\_

Are you currently in a committed relationship? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you have children? (if yes, please list ages) \_\_\_\_\_

Who do you primarily go to for support or comfort? \_\_\_\_\_

Do you have a supportive network of friends or family? \_\_\_\_\_

Do you consider yourself to be spiritual or religious, or do you have any cultural or religious considerations that you want to share? \_\_\_\_\_

How do you spend your leisure time? \_\_\_\_\_

Have you turned toward any of the following for comfort (drugs/alcohol/shopping/gambling/food/pornography/or other material things)? \_\_\_\_\_

**Relationships**

**For your current primary partner:**

On a scale of 1 (low) to 5 (high) how would you rate:

Commitment to relationship:  
1      2      3      4      5

Level of distress in relationship  
1      2      3      4      5

What is your identified sexual/romantic orientation? \_\_\_\_\_

Are you experiencing any difficulties with your sexual relationship? \_\_\_\_\_

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**Family History**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

|                                         |                          | Relationship? |
|-----------------------------------------|--------------------------|---------------|
| <b>Alcohol/Substance Abuse</b>          | <input type="checkbox"/> |               |
| <b>Anxiety</b>                          | <input type="checkbox"/> |               |
| <b>Bipolar Disorder</b>                 | <input type="checkbox"/> |               |
| <b>Depression</b>                       | <input type="checkbox"/> |               |
| <b>Domestic Violence</b>                | <input type="checkbox"/> |               |
| <b>Eating Disorder</b>                  | <input type="checkbox"/> |               |
| <b>OCD</b>                              | <input type="checkbox"/> |               |
| <b>Schizophrenia/Psychotic Disorder</b> | <input type="checkbox"/> |               |
| <b>Suicide Attempts</b>                 | <input type="checkbox"/> |               |
| <b>Other</b>                            | <input type="checkbox"/> |               |

Who did you go to for comfort/support in your family growing up? \_\_\_\_\_

Who were your primary caregivers growing up? (are they still living?) \_\_\_\_\_

Do you have siblings? (if so, what is the quality of this relationship?) \_\_\_\_\_

Choose three adjectives to describe your mother (or other primary caregiver):

Choose three adjectives to describe your father (or other primary caregiver):

Please comment on any other significant relationships that have been influential in your experience growing up: \_\_\_\_\_

**Education and Work**

Highest Level Completed:

High School    GED    Some College    Bachelors    Masters    Professional    Other

Are you currently employed (if so, where?): \_\_\_\_\_

Part time                      Fulltime                      Seasonal                      Volunteer                      Other

If you have a primary partner, what is their level of education and occupation? \_\_\_\_\_

Are you in school now? (If yes, please provide area of study and name of school): \_\_\_\_\_

Are you currently experiencing any difficulties at work or school? \_\_\_\_\_

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**Military History** (If Applicable)

Have you ever served in any branches of the military? How Long? \_\_\_\_\_

Are you an active duty or reserve service member? \_\_\_\_\_

Were you ever deployed during your service? \_\_\_\_\_

Are you experiencing any behavioral health concerns related to your service? \_\_\_\_\_

Please explain any other relevant Military history? \_\_\_\_\_

**Legal Issues**

Do you have a history of or are you currently experiencing any legal problems? \_\_\_\_\_

\_\_\_\_\_

**Other**

Is there any other information you would like to provide that you think may help the therapist understand you better? \_\_\_\_\_

\_\_\_\_\_