ADULT INTAKE FORM

Please briefly describe the situation and/or issues which led you to seek counseling at this time:

_____

_____

_____

_____

Have you had any recent life transitions in the past 6 months?

_____

_____

_____

What are your goals that you wish to accomplish through counseling?

_____

_____

_____

CLIENT INFORMATION

Client's Name: _____

Gender: M F Age: _____ Birth date: _____

Birth Place: _____ (city): _____ State: _____

Home/Billing Address:

_____

Email:

_____

Primary Contact #: _____

Referring Physician: _____ Phone #: _____

Client Occupation : _____

Place of Employment: _____

Check One: ___ Full-Time___ Part-Time ___On Disability ___Unemployed

Marital Status: ___Never Married ___Married ___Separated ___ Divorced

___Widowed ___Common Law ___Engaged ___ Partners

Spouse/Partner's Name : _____

Employment: _____

Gender: M F Age: _____ Birth date: _____

Married: ____years

Primary Contact #_____

Important persons to contact in case of emergency (Please provide name and telephone number):

[ ] Spouse: _____ Phone #: _____

[ ] Parent: _____ Phone #:_____

[ ] Other: _____ Phone #: _____

PERSONAL HISTORY

Primary Language: _____

Ethnicity: _____

Was the client adopted? Yes___ No ___

Lived at any time in foster care? Yes___ No ____

Is the client a student? Yes___ No ___

Name of School/College _____

___Part-Time Student ___Full-Time Student

Highest grade/education/degree completed _____

Children and/or dependents, their ages, and where they live:

_____

_____

_____

_____

_____

Current Drug Use: over the counter, prescription and/or recreational drug use (whether the drug is legal or illegal):

_____

_____

_____

_____

How often do you use alcohol? Circle the most appropriate response:

Never Occasionally Weekly Daily

Please list any current legal issues:

_____

_____

_____

_____

Referred By? How Did You Hear About Us? (Check all that apply):

____ Internet
____ Client/Former Client
____ Friend/Relative
____ Pastor/Church Leader

MEDICAL HISTORY & QUESTIONNAIRE

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.
Please check **ALL** of the following symptoms or thoughts that apply to you AT THIS TIME or during the past six months:

__Depressed Mood
__Diminished interests or pleasure
__Sleep disturbance
__Fatigue
__Change in appetite
__Hopelessness
__Pleasure in few activities
__Weight change
__Agitation
__Excessive worry
__I feel like I am losing control
__Irritability
__Poor concentration
__Tension
__Feelings of panic
__Socially withdrawn
__Use of alcohol
__Abuse of other drugs
__Use of tobacco
__Anxiety in social settings
__Makes careless mistakes
__Does not complete tasks
__Difficulty organizing
__Forgetful
__Confusion
__Disorientation
__Compulsive checking/counting
__Indecisiveness
__Recurrent thoughts that people are talking about me
__Recurrent thoughts that people want to hurt me
__I feel emotionally distant from others
__I hear voices or sounds others do not hear
__I see things others do not see
__I smell things others do not smell
__Racing thoughts
__I do risky or dangerous things
__Little interest in sexual activity
__Sexual problems
__Gender concerns
__I don't like my body
__Binge eating
__Self-induced vomiting
__Laxative abuse
__Excessive fasting
__Intense fear of weight gain
__Impulsive
__I think about hurting myself
__I have tried to hurt myself
__Sometimes I wish I were dead
__I think about hurting someone else
__Exposed to a significant traumatic event
__Recurrent distressing dreams

PSYCHIATRIC/COUNSELING HISTORY

I have received treatment for:
___ Substance Abuse ___ Mental Health Issues ___ Both

The treatment occurred at:
___ Private Psychiatrist
___Private counselor/therapist
___Mental Health center
___Hospital
___Other

Are you presently being treated by a psychiatrist? ___ yes ___ no If yes, by whom? _____

Are you presently being treated by a counselor? ____ yes ____ no
If yes, by whom? _____
Have you previously been treated by a counselor? ____ yes ____ no
If yes, by whom? _____

MEDICAL HISTORY

Your current weight: _____ Height in inches: _____

Name of your primary care doctor: _____

Phone #: _____

Date last seen: _____

Do you have a history of any medical problems? __ Yes __ No

If so, what? _____

Are you presently being treated for any medical problems? __ Yes __ No If so, what?

_____

Past Surgeries and dates:

_____

_____

Do you have allergies? If so, what are they?

_____

Are currently being treated for allergies? __yes __no

Have you ever been treated for a nutritional problem? __ yes __no

Do you make yourself sick because you feel uncomfortably full? __yes __no

Do you worry you have lost control over how much you eat? __yes __no

Have you recently lost more than 14 pounds in a 3-month period? __yes __no

Do you believe yourself to be fat when others say you are too thin? __yes __no

Would you say that food dominates your life? __yes __no

Are you experiencing any physical pain? __yes __no

Have you ever received treatment for any of the following medical conditions?

__Neurological impairment
__Seizure disorder
__Visual loss/impairment
__Hearing loss/impairment
__Dementia
__GI disorder
__Obesity
__Significantly underweight
__Cirrhosis
__Hepatitis
__Heart condition
__Hypertension
__Asthma
__Emphysema
__Chronic bronchitis
__Tuberculosis/ +PPD
__Cancer
__Thyroid disease
__Diabetes
__Pregnancy
__Irregular menstrual periods
__Musculoskeletal condition
__HIV/AIDS/Related condition
__Other

REVIEW OF MEDICAL SYSTEMS

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes as directed. Your cooperation is appreciated. Please check **ALL** of the following symptoms or thoughts that apply to you AT THIS TIME or within the past month.

General-
- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

Skin-
- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair and nail changes

Neurologic-
- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

Vascular-
- Calf pain with walking
- Leg cramping

Eyes-
- Vision loss/Changes
- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts
- Last eye exam _____

Cardiovascular-
- Chest Pain or discomfort
- Tightness
- Palpitations
- Shortness of breath with activity
- Swelling
- Difficulty breathing lying down
- Sudden awakening from sleep with shortness of breath

Respiratory-
- Cough
- Sputum
- Coughing up blood
- Shortness of breath
- Wheezing
- Painful breathing

Gastrointestinal-
- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Yellow eyes or skin

Head-
- Headache
- Head Injury
- Neck Pain

Nose-
- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

Throat-
- Dry mouth
- Sore Throat
- Hoarseness
- Thrush
- Non-healing sores

Neck-
- Lumps
- Swollen glands
- Pain
- Stiffness

Breasts-
- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

Gastrointestinal-
- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Yellow eyes or skin

Urinary-
- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in urinary strength

Musculoskeletal-

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

The first session evaluation fee is $110.00. Additional session fees will follow the schedule below. Please check the box with your income level.

SCHEDULE OF FEES:

[ ] 40,000 and below	**$60**
[ ] 41,000 - 60,000	**$70**
[ ] 61,000 - 70,000	**$80**
[ ] 71,000 - 90,000	**$90**
[ ] 91,000 - and over	**$100**

I have read and understand this document:

Client Signature:_____Date:_____

Client Signature:_____Date:_____

Client Representative Signature:
_____Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information (PHI) may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

- Request and review a copy of your paper or electronic treatment record (appropriate fees may apply).
- Request confidential communication: *You must sign a Release of Information Form in order for us to communicate with friends, family, coworkers, attorneys, etc.*
- Ask us to limit the information we share: *You may specify your requests on a Release of Information Form.*
- Pay full price for your therapy and request that your counselor keep session notes and diagnoses private from your health insurance provider.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice,
- File a complaint if you believe your privacy rights have been violated.
    - If you are concerned that I have violated your privacy rights, or you disagree with the decision I made about access to your records, you may also send a written complaint the secretary U.S. Department of Health and Human Services.

Our Uses and Disclosures

We may use and share your information as we:

- **Treat you**: *We may obtain records from other medical or mental health professionals that you have previously seen.*
- **Run our organization**: Counselors *and business associates may access your information in order to collect payment, schedule appointments, or communicate with you or those you give us permission to contact.*
- **Bill for your services**: *Business Associates or your counselor may contact your health insurance provider or a designated payer to obtain payment for services*
- **Comply with the law***: *We are required to report suspected abuse, neglect, or intent to harm self or others. **
- **Address law enforcement and other government requests**
- **Respond to illegal behavior, lawsuits, and legal actions**: *We are required to respond to court orders by providing session notes and by possibly testifying in court. We will contact local authorities should illegal activity occur on our premises.*

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information. We will never disclose your PHI for marketing or fundraising activities: *All counselors and business associates of utilize HIPAA- compliant electronic communication services. All paper and digital PHI records are stored, secured, and disposed of as outlined in HIPAA guidelines.*
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge the receipt of the Notice of Privacy Practices of your counselor. This Notice of Privacy Practices provides information about how your counselor and business associates may use and disclose your protected health information. We encourage you to read it in full.

This Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by your counselor. If you have any questions about our Notice of Privacy Practices, please contact:

Your Counselor:

Tina Howard: 251.308.6838
Linda Hembree: 251.333.0321
Rachel Taylor: 251.219.0426
Lisa Smith: 251.265.4181
Jerry Mott: 251.380.0215

I acknowledge the receipt of the Notice of Privacy Practice.

Client's Name: _____

Signature: _____ Date: _____
(client/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Client's Name: _____

Reasons why the acknowledgement was not obtained:

Client refused to sign this acknowledgement even though the client was asked to do so and was given the Notice of Privacy Practices.

Other:
Signature of provider representative: _____ Date: _____