

Please fill out this form and bring it to your first appointment at the FRC Annex (191 Jefferson Street, Clarkesville).



ADULT INTAKE INFORMATION

This Form is Confidential

Today's Date _____

Name _____ Birth Date _____

Age _____ Email Address: _____

Home Address _____ City _____ Zip _____

Best contact number: _____ Cell _____ Home _____

May we leave a voice or text message? Yes No

Employer _____ Occupation _____

Employer Address _____ City _____ Zip _____

Highest Education Completed (Circle): Some High School, High School Diploma, Some College, Technical School, Associates Degree, Bachelors Degree, Graduate school or higher.

Who referred you to this office? _____

If referred by a doctor or other clinician would you like for us to communicate with them? Yes No

Emergency Contact Name _____ Phone _____

Relationship: _____

Medical History

Approximate Height: _____ Weight: _____ Gender: _____

Briefly describe your diet and exercise patterns:

Do you smoke or use tobacco? Yes No If yes, how much per day? _____

Do you consume caffeine? Yes No If yes, how much per day? _____

Do you drink alcohol? Yes No If yes, how much per day? _____

Do you use any non-prescription drugs? Yes No If yes, how much per day?

Have any of your friends or family members voiced concern about your substance use? ___Yes ___No

If yes, why? _____

Have you ever been in trouble or risky situations because of your substance use? ___Yes ___No

Are you Disabled? ___Yes ___No If yes please describe:

Please explain any medical problems, symptoms or illnesses:

Previous medical hospitalization approximate dates and reasons:

Previous psychiatric hospitalization approximate dates and reasons:

Please list current medications (list any additional medications on the back of this form if needed)

Name of Medication	Dosage	Purpose	Prescribing Doctor

Counseling Questions

Have you ever previously received counseling or consulted with a psychiatrist, psychologist or other mental health professional for services? ___Yes ___No

If yes, please describe approximately when and why services were obtained.

Did you find counseling helpful for you? _____

Why was prior counseling terminated or ended?

Please describe your reasons for your visit today.

What are your goals for therapy?

How long do you expect to be in therapy in order to accomplish these goals?

Mental Health Symptoms

Please indicate any symptoms past & present on a scale from 0 (never) to 5 (all the time/severe):

DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past
Depression			Anxiety			Intense Fears		
Feeling Hopeless			Irritability			Nightmares		
Loss of Interest			Agitated/Restless			Feeling Numb/Detached		
Sleep too much			Fidgety			Easily Startled		
Sleep too little			Angry/Resentful			Obsessive Thoughts		
Excessive weight gain			Argumentative			Repetitive Behaviors		
Excessive weight loss			Dizziness			Overly Stressed		
Low Energy/Fatigue			Headaches			Sexual Concerns		
Memory Loss			Shortness of Breath			Domestic Violence		
Poor Concentration			Chills or Hot Flashes			Legal Problems		
Social Isolation			Heart Racing/Chest Pain			Financial Problems		
Grief			Muscle Tension			Drug Use		
Mood Swings			History of Head Injury			Alcohol Use		
Episodes of Crying			Blackouts			Chronic Pain		
Thoughts of Death			Completing Tasks			Problems at Work		
Self-Mutilation/Harm			Hyperactive			Problems at Home		
Suicide Attempt			Paying Attention			Problems with Friends		
Thoughts of Hurting Someone Else			Easily Distracted by Noise			History of Abuse/Neglect		

Family Relationships, Social Support and Self Care

Mother's age (or age at death) _____ How would you describe your relationship with your mother?

Father's age (or age at death) _____ How would you describe your relationship with your father?

If alive, are your parents still married? ____Yes ____No If they are divorced how old were you when they separated or divorced and how did this impact you?

Were there any other primary care givers who you had a significant relationship with? If so please describe who and how this person impacted your life:

How many sisters do you have? _____ List names and ages:

How many brothers do you have? _____ List names and ages:

How would you describe your relationship with your siblings?

Briefly describe any history of abuse, neglect and/or trauma:

Please indicate if there is a family history of any of the following (if there is, indicate the family member's relationship to you: for example, father, grandmother, brother etc.) Alcohol/substance abuse, anxiety, bipolar disorder, adoption, depression, domestic violence, foster care, eating disorders, hyperactivity, learning disabilities, legal trouble, "nervous breakdown", obesity, obsessive compulsive behavior, sexual abuse, schizophrenia, suicide attempts, trauma, or other.

Are you currently in a relationship? ___ Yes ___ No If yes for how long? ___

Married/Life Partner? ___ Yes ___ No If yes for how long? ___

Satisfaction with current relationship? (1 to 5 with 1 = lowest and 5 = highest) 1 2 3 4 5

Occupation of partner _____ Employer _____

Previously Married/Life Partnered? ___ Yes ___ No

If yes, length of previous relationship _____

Do you have children ___ Yes ___ No If yes list names and ages:

Describe any problems any of your children are having.

List the names and ages of anyone currently living in your household.

What is your current level of satisfaction with friends and any social supports?

(1 to 5 with 1 = lowest and 5 = highest) 1 2 3 4 5

Please list the names of those who you would consider your close friends and can lean on in times of distress.

What are some of your strengths?

Is spirituality important in your life? ___ Yes ___ No Please explain:

Is there anything else you would like to share or feel your counselor should know about you and/or your circumstances before you begin working together? Please specify:

If involved with other agencies, please complete below:

Agency	Caseworker Name & Contact Information
Law Enforcement	
DFCS	
Guardian Ad Litem	
Attorney	
Circle of Hope	
Other	

Acknowledgement of Receipt of Information

By initialing and signing below you agree to all the terms set forth by the Family Resource Center-Prevent Child Abuse Habersham Counseling Program.

- _____ Please initial here if you have read the policies on appointment cancellations and the procedures for contacting your therapist in the Welcome Packet (pg. 1).
- _____ Please initial if you have been informed on the location of the HIPPA Notice of Privacy Practices at the Family Resource Center Annex (pg. 4). You may request a copy at any time.
- _____ Please initial here if you have read the emergency services phone numbers in the Welcome Packet (pg. 2).

CONSENT TO RECEIVE SERVICES

I, _____, hereby consent and give permission to the Family Resource Center to provide counseling services to me and/or my child and I agree to abide by all policies, instructions, and rules set forth by the Family Resource Center. I further agree not to subpoena: (a) any records relating to the services I or my child receives from the Family Resource Center, or (b) the testimony of any therapist or other person employed or affiliated with the Family Resource Center.

To the extent that a court orders a therapist or other Family Resource Center Staff member to appear in court notwithstanding this agreement, all associated time will be billed to the person who issued the subpoena or caused it to be issued at a rate of \$400.00 per hour.

The rate of \$400.00 per hour will be charged for all activities related to the subpoena, including but not limited to communicating with lawyers or the guardian ad litem, traveling to/from the courthouse, waiting at the courthouse, and reviewing notes.

Date: _____

Signature of Client, Parent, Guardian, or Personal Representative

Printed Name

NOTE: If you are signing as a personal representative of an individual, please describe below your authority to act for this individual (parent, guardian, power of attorney, healthcare surrogate, etc.).

