



## Adult Intake Form

Today's Date: \_\_\_\_\_

### **Identifying/Contact Information:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

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

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Email Address: \_\_\_\_\_ OK to email confidential messages? ☐ Y ☐ N

Racial/Ethnic Background: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
OK to leave confidential messages? ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N

Presently living with: \_\_\_\_\_

How did you first hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Current Situation**

Briefly describe the reason you are seeking counseling: \_\_\_\_\_

When has the problem improved? Who else was involved? \_\_\_\_\_

When has the problem worsened? Who else was involved? \_\_\_\_\_

Do you have any concerns about the way anger is handled in your relationships? \_\_\_\_\_

Has your partner, if any, ever pushed, shoved, or hit you? \_\_\_\_\_

Is there anything else that you believe might be important for your counselor to know at this time? \_\_\_\_\_

### **Education**

Years of education completed (K-12, College: 13-16+): \_\_\_\_\_ Degrees received: \_\_\_\_\_

Specialized training or trade school: \_\_\_\_\_

Did you have any trouble learning in school? \_\_\_\_\_

Do you have any learning or developmental disabilities? Please specify: \_\_\_\_\_

Do you have any background/experiences in the military? ☐ Describe briefly: \_\_\_\_\_

Current spouse's (if any) years of education: \_\_\_\_\_ Degrees: \_\_\_\_\_

**Occupation**

Primary place of work? \_\_\_\_\_ How long there? \_\_\_\_\_

Describe the nature of your work: \_\_\_\_\_

Do you find this work satisfying? \_\_\_\_\_ Other current employment: \_\_\_\_\_

Total number of work hours per week: \_\_\_\_\_

Current spouse's (if any) occupation: \_\_\_\_\_

**Current and Past Relationships**

Current Marital Status (check one only):

☐ Never married ☐ Living Together ☐ Married ☐ Separated ☐ Divorced ☐ WidowedList marriages (if any), starting with most recent:

Date of Marriage	Your Age at Marriage	Spouse's Name	Spouse Age at Marriage	Number of Yrs Married	Reason for End
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Total number of your marriages: \_\_\_\_\_ Number of current spouse's (if any) previous marriages: \_\_\_\_\_

Children's Names	Age	Yours? (✓)	Quality of Relationship (Circle one)				
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact

List additional significant relationships (friends/relatives) \_\_\_\_\_

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

**Family Background**

Were your parents married (either before or after your birth)? ☐ Yes ☐ No

**Father's Name:** \_\_\_\_\_ **Age (if living):** \_\_\_\_\_

☐ Deceased? **Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Cause:** \_\_\_\_\_

**Grade completed in school (or highest degree):** \_\_\_\_\_ **Occupation (when working)** \_\_\_\_\_

**Medical, psychiatric, substance abuse problems, if any:** \_\_\_\_\_

**Quality of relationship currently:** \_\_\_\_\_ **In childhood:** \_\_\_\_\_

List Father's marriages (if any), starting with the first (total number of Father's marriages: \_\_\_\_\_):

	Date of Marriage	Your Age at Marriage (0 if unborn)	Spouse's name (Your Mother? [✓])	Number of Yrs Married	Reason for End	Quality of Relationship with Step-Parent (circle one, if applicable)
1.	_____	_____	_____	_____	_____	Good Average Poor N/A
2.	_____	_____	_____	_____	_____	Good Average Poor N/A
3.	_____	_____	_____	_____	_____	Good Average Poor N/A
4.	_____	_____	_____	_____	_____	Good Average Poor N/A

**Mother's Name:** \_\_\_\_\_ **Age (if living):** \_\_\_\_\_

☐ Deceased? **Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Cause:** \_\_\_\_\_

**Grade completed in school (or highest degree):** \_\_\_\_\_ **Occupation (when working)** \_\_\_\_\_

**Medical, psychiatric, substance abuse problems, if any:** \_\_\_\_\_

**Quality of relationship currently:** \_\_\_\_\_ **In childhood:** \_\_\_\_\_

List Mother's marriages (if any), starting with the first (total number of Mother's marriages: \_\_\_\_\_):

	Date of Marriage	Your Age at Marriage (0 if unborn)	Spouse's name (Your Father? [✓])	Number of Yrs Married	Reason for End	Quality of Relationship with Step-Parent (circle one, if applicable)
1.	_____	_____	_____	_____	_____	Good Average Poor N/A
2.	_____	_____	_____	_____	_____	Good Average Poor N/A
3.	_____	_____	_____	_____	_____	Good Average Poor N/A
4.	_____	_____	_____	_____	_____	Good Average Poor N/A

**Siblings:** Name \_\_\_\_\_ Step/Half/Full \_\_\_\_\_ Age \_\_\_\_\_ Quality of Relationship (Circle one) \_\_\_\_\_

_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact
_____	_____	_____	Very Close	Close	Average	Distant	No Contact

Other important childhood relationships: \_\_\_\_\_

Significant childhood events (divorce, deaths, sickness, traumas, accidents, injuries, etc.) \_\_\_\_\_

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### **Medical History**

Do you have any physical disabilities that need special accommodations at Fountain Gate? \_\_\_\_\_

Explain: \_\_\_\_\_

Describe any physical problems that require medication or physical care:

Current: \_\_\_\_\_

In the Past (including surgeries and hospitalizations): \_\_\_\_\_

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When did you last consult your primary care physician? \_\_\_\_\_

Who is your primary care physician? (name, address) \_\_\_\_\_

Other physicians whose care you regularly receive: \_\_\_\_\_

Please list your medications here:

<u>Name</u>	<u>Dosage</u>	<u>For what condition?</u>	<u>Who prescribed it?</u>

Check any of the following problems you experience:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Pain               | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Trouble staying asleep | <input type="checkbox"/> Low energy         | <input type="checkbox"/> Flashbacks               |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Panic attack             |
| <input type="checkbox"/> Stomach problems       | <input type="checkbox"/> Obsessive thoughts |   |

Sleep habits: Number of hours sleeping in a 24 hour period: \_\_\_\_\_ Usual bedtime: \_\_\_\_\_

Eating habits: Number of meals per day: \_\_\_\_\_ Recent appetite loss or gain? \_\_\_\_\_

Recent weight loss/gain? \_\_\_\_\_ Concerned about: ☐ Binging ☐ Purging ☐ Skipped meals

Exercise habits: How much per week? (circle) 0x 1-2x 3-4x 5x What type? \_\_\_\_\_

**Drug/Alcohol History**

Have you used alcohol or other drugs in the past month? If so, describe average usage per week: \_\_\_\_\_

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Have you had any problem in the following areas related to your substance use? (Check any that apply):

\_\_\_ Family \_\_\_ Friends/Social \_\_\_ Employment \_\_\_ Finances \_\_\_ Health \_\_\_ Legal  
 \_\_\_ Self-esteem \_\_\_ Other: \_\_\_\_\_

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My substance use is (check one only): \_\_\_ Not a problem \_\_\_ Becoming a problem \_\_\_ A problem

I have attended: \_\_\_ 12-step meetings \_\_\_ Treatment program \_\_\_ Addiction therapy

Longest period of sobriety and when: \_\_\_\_\_

How did you stay clean/sober? \_\_\_\_\_

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**Spiritual Background**

Religious affiliation (if any): \_\_\_\_\_

Do you regularly attend religious services? \_\_Y \_\_N If yes, where? \_\_\_\_\_

What role does religion or spirituality have in your life? \_\_\_\_\_

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Describe any relationships that that are supportive for you spiritually: \_\_\_\_\_

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**Counseling History**

Have you had previous counseling/therapy? \_\_\_Yes \_\_\_No

If yes, when? For how long? \_\_\_\_\_

With Whom? (name, address) \_\_\_\_\_

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Is there anything you'd like us to know about your previous therapists? \_\_\_\_\_

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Have you ever been hospitalized for a psychiatric condition? \_\_\_Yes \_\_\_No

If yes, please describe briefly: \_\_\_\_\_

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List what you feel are your supports and resources: \_\_\_\_\_

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What are the goals you hope to reach through counseling? \_\_\_\_\_

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**Current Concerns**

Using the scale below, please choose a number that reflects the extent of your current concern about the issues listed below. Please rate each item.

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
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**No concern****Moderate concern****Extreme concern**

<p>___ Abused as a child</p> <p>___ Aggression</p> <p>___ Anger or Temper</p> <p>___ Anxiety</p> <p>___ Bitterness</p> <p>___ Completing Tasks</p> <p>___ Concentration</p> <p>___ Depressed Mood</p> <p>___ Difficulty in communication</p> <p>___ Eating Difficulties</p> <p>___ Excessive Behaviors</p> <p>___ Family Problems</p> <p>___ Fearfulness</p> <p>___ Feeling Manic</p> <p>___ Feeling Overwhelmed</p> <p>___ Fidget Frequently</p> <p>___ Fatigue</p> <p>___ Finances</p> <p>___ Frustration</p> <p>___ Grief or Loss</p> <p>___ Hard to Focus</p> <p>___ Feeling Helpless</p> <p>___ Feeling Hopeless</p> <p>___ Irritability</p> <p>___ Isolation</p>	<p>___ Marital Problems</p> <p>___ Nervousness</p> <p>___ Nightmares</p> <p>___ Loss of Interest in Pleasurable Activities</p> <p>___ Personality Conflicts</p> <p>___ Physical Problems</p> <p>___ Problems in Relationships</p> <p>___ Problems with Children</p> <p>___ Problems with Parents</p> <p>___ Resentment</p> <p>___ Sadness</p> <p>___ Sexual Concerns</p> <p>___ Sleep Problems</p> <p>___ Social Withdrawal</p> <p>___ Spiritual Concerns</p> <p>___ Stress</p> <p>___ Thoughts of Hurting Yourself</p> <p>___ Thoughts of Suicide</p> <p>___ Trouble Making Decisions</p> <p>___ Unhappy Most of the Time</p> <p>___ Drug or Alcohol Use</p> <p>___ Drug or Alcohol Use by a Family Member</p> <p>___ Work</p> <p>___ Worry</p> <p>___ Other: _____</p>
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**Please Complete the following:**

1. The most important thing to me is
2. I worry about
3. What I do best is
4. Sometimes I feel guilty about
5. One of the things I'm angry about is
6. My biggest mistakes were
7. My job
8. What makes me nervous is
9. My personality would be better if
10. I often felt that mother
11. One thing I have a hard time forgiving is
12. My temper
13. My childhood
14. Prayer is
15. My biggest disappointment
16. To me, sex is
17. I would be better liked if
18. I often felt that father
19. God to me is
20. My children (child)
21. Women are
22. What hurts me most is
23. It is hard for me to admit
24. Men are



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

## Brief Mood Survey\*

**Instructions.** Use checks (✓) to indicate how depressed, anxious or angry you've been feeling **over the past week, including today.** Please answer all the items.

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
<b>Depression</b>					
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem, inferiority, or worthlessness					
4. Loss of motivation to do things					
5. Loss of pleasure or satisfaction in life					
<b>Total Items 1 to 5 →</b>					

### Suicidal Urges

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Have you had any suicidal thoughts?					
2. Would you like to end your life?					
<b>Total Items 1 to 2 →</b>					

### Anxiety

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
<b>Total Items 1 to 5 →</b>					

### Anger

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
<b>Total Items 1 to 5 →</b>					

## Relationship Satisfaction\*

**Instructions.** Use checks (✓) to show how satisfied or dissatisfied you feel in your closest personal relationship.

**Please answer all 5 items.**

	Dissatisfied			Satisfied			
	0—Very	1—Moderately	2—Somewhat	3—Neutral	4—Somewhat	5—Moderately	6—Very
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Overall satisfaction							
<b>Total Items 1 to 5 →</b>							





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

## Relationship Satisfaction Scale \*

**Instructions:** Place a check (✓) in the box that best describes how much relationship satisfaction you feel in your closest relationship. **Please answer all 13 items.**

	0 – Very dissatisfied	1 – Moderately dissatisfied	2 – Somewhat dissatisfied	3 -- Neutral	4 – Somewhat satisfied	5 – Moderately satisfied	6 – Very satisfied
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Handling of finances							
4. Sexual satisfaction							
5. Recreational activities and leisure time							
6. Sharing duties and household chores							
7. Raising children <sup>1</sup>							
8. Affection and caring							
9. Relating to friends and relatives							
10. Intimacy and closeness							
11. Satisfaction with your role in the relationship							
12. Satisfaction with your partner's role							
13. Overall satisfaction							

Please Total Your Score on Items 1 to 13 Here →

\* Copyright (c) 1983 by David D. Burns, M.D. (Revised 1996, 1997.)

<sup>1</sup> If you have no children, please put your overall satisfaction for this item. For example, if you are very satisfied with your relationship overall, put very satisfied for item #7.



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Kennesaw, GA 30144

770-218-9005

fountaingate.com

## Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the “Counseling Information and Agreement” document. I understand that I am free to discuss any aspect of my treatment with my therapist at any time.

I consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand the benefits and risks of therapy and that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand the provisions and limits of confidentiality established by Federal (HIPAA) and Georgia laws.

I understand that Clinical Interns (Masters degree students) and Intermediate-Licensed Therapists (LAPC, LAMFT, LMSW) work under a licensed clinical supervisor who has full access to my records and who maintains client confidentiality.

I am aware that I may stop my treatment with this therapist at any time. My only remaining responsibility will be to pay for the services I have already received.

If I am acting on behalf of a minor, or a developmentally disabled or incapacitated adult, I agree to supply Fountain Gate with copies of any current or updated custodial, guardianship, or Power-of-Attorney arrangements that may be in effect.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel with 24 hours notice or do not show up, my account will be charged the full session fee for that appointment, and any credit/debit card on file for my account will be used to collect payment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that services rendered by Clinical Interns and Intermediate-Licensed Therapists (LAPC, LAMFT, LMSW) are not eligible for insurance payments.

I understand that if payment for the services I receive here is not made, my therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

\_\_\_\_\_  
Signature of client (**OR** parent/guardian/attorney-in-fact acting for client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of signer above

\_\_\_\_\_  
Relationship to client (if necessary)

\_\_\_\_\_  
Printed name of client (if different than above)

I, the therapist undersigned below, have discussed the issues above with the client (and/or his or her parent, guardian, attorney-in-fact, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to treatment.

\_\_\_\_\_  
Signature of therapist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of therapist

\_\_\_\_\_  
Printed name and credentials of Clinical Supervisor (if applicable)



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## Privacy Practices Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients with notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

Please read our Notice of Privacy Practices, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, we make every effort to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification. Please read the following paragraph and sign your agreement below.

**I have read and understand Fountain Gate’s Notice of Privacy Practices, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may, at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document.**

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Signature of client (OR parent/guardian/attorney-in-fact acting for client)

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Date

---

Printed name of signer above

---

Relationship to client (if necessary)

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Printed name of client (if different than above)