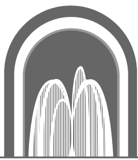

Adult Intake Form

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 ___Widowed

List 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.) ____________

____

____

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): ____________________

____

____

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:

Name	Dosage	For what condition?	Who prescribed it?

Check any of the following problems you experience:

___ Trouble falling asleep
___ Trouble staying asleep
___ Fatigue
___ Stomach problems
___ Pain
___ Low energy
___ Headaches
___ Obsessive thoughts
___ Difficulty concentrating
___ Flashbacks
___ Panic attack

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: ______

____

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: ____

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? ____

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? ____________________________________

____

Describe any relationships that that are supportive for you spiritually: ________________________

____

Counseling History

Have you had previous counseling/therapy? ___Yes ___ No

If yes, when? For how long?____

With Whom? (name, address)____

____

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

____

Have you ever been hospitalized for a psychiatric condition? ___Yes ___No

If yes, please describe briefly: ____

____

List what you feel are your supports and resources:___________________________________

____

What are the goals you hope to reach through counseling? ______________________________

____

____

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.

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

____ Abused as a child
____ Aggression
____ Anger or Temper
____ Anxiety
____ Bitterness
____ Completing Tasks
____ Concentration
____ Depressed Mood
____ Difficulty in communication
____ Eating Difficulties
____ Excessive Behaviors
____ Family Problems
____ Fearfulness
____ Feeling Manic
____ Feeling Overwhelmed
____ Fidget Frequently
____ Fatigue
____ Finances
____ Frustration
____ Grief or Loss
____ Hard to Focus
____ Feeling Helpless
____ Feeling Hopeless
____ Irritability
____ Isolation

____ Marital Problems
____ Nervousness
____ Nightmares
____ Loss of Interest in Pleasurable Activities
____ Personality Conflicts
____ Physical Problems
____ Problems in Relationships
____ Problems with Children
____ Problems with Parents
____ Resentment
____ Sadness
____ Sexual Concerns
____ Sleep Problems
____ Social Withdrawal
____ Spiritual Concerns
____ Stress
____ Thoughts of Hurting Yourself
____ Thoughts of Suicide
____ Trouble Making Decisions
____ Unhappy Most of the Time
____ Drug or Alcohol Use
____ Drug or Alcohol Use by a Family Member
____ Work
____ Worry
____ Other: ________________________________

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.**

Depression	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
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					
Total Items 1 to 5 →					

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?					
Total Items 1 to 2 →					

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					
Total Items 1 to 5 →					

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

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							
Total Items 1 to 5 →							

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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[1]							
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 → ______

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[1] **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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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 my therapist operates under the professional and ethical standards of the American Counseling Association (ACA), the American Association for Marriage and Family Therapy (AAMFT), and/or the National Association of Social Workers (NASW), as appropriate to my therapist's specialization, and to the Ethics Standards of the Christian Association for Psychological Studies (CAPS).

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.

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 or do not show up, my account will be charged the full session fee for that appointment, and any credit 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 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/guarding acting for client)	Date
Printed name	Relationship to client (if necessary)

I, the therapist undersigned below, have discussed the issues above with the client (and/or his or her parent, guardian, 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	

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Notice of Privacy Practices Confirmation

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.

____
Printed name of client

____
Printed name of parent/guardian, if applicable

____ ____________________
Signature of client, Date
Or parent/guardian (for clients under 18 years of age)