CLIENT INTAKE INFORMATION FORM

Office Use Only

Client #______________ Ins Dx ______________
Therapist ______________ Ther# _____ Ctr# ____
Need Monthly Statement? Y N
EAP? Y N GBC? Y N

Today's Date ____________

The information requested in this form will be kept confidential and will help your counselor assist you.

GENERAL INFORMATION - ***Please print***

Name: Last_______________________ First _______________________ MI _____
Mailing address_______________________ City_______________ State________ Zip_________

Responsible Party (if different than above)
Name: Last_______________________ First _______________________ MI _____
Mailing address_______________________ City_______________ State________ Zip_________

Phone (circle preferred number) Leave message?
Home______________________ Y N
Work______________________ Y N
Cell ______________________ Y N

Email Address ___________________________
Would you like to be on our email list for upcoming workshops and groups? Y N

Birth date ____ /____ /____ Age______ ❑ Male ❑ Female Social Security # ____________________
Place of employment____

Your racial/ethnic identity: ❑ African-American ❑ Native-American ❑ Asian-American ❑ White/Caucasian ❑ Hispanic ❑ Other__________

Marital Status: ❑ Single ❑ Married/Partnered (# years_____) ❑ Separated ❑ Divorced ❑ Widowed
Spouse/Partner's Name ________________________________

How did you hear about us? ❑ Clergy ❑M.D. ❑ Brochure ❑ Family/Friend ❑Internet ❑Insurance ❑Therapist ❑ CCCG Client Referred by_______________________________
Religious/denominational preference: ____

Type of counseling you are seeking: ❑ Individual ❑ Couples ❑ Family

EMERGENCY CONTACT Name ___________________________Relationship ______________Phone ___________

Are you using insurance benefits? ❑Y or ❑N Are you: ❑ Primary Policyholder or ❑ Dependent
Insurance Company Name: ___________________________ Insurance Company Phone #:__________________
Insurance ID #_________________ Group #____________________ Policyholder's SSN:__________________
Policyholder's Name:_______________________________________ Policyholder's Birthday:________________
Relationship to Policyholder:_______________ Policyholder's Employer: _________________________________

Client's Authorization for Insurance Use

I authorize the release of health care information necessary To process any claims generated by Care and Counseling Center of Georgia.

____
Client's Signature Date

Client's Payment Agreement

I hereby authorize payment directly to Care and Counseling Center of Georgia of any benefits due me for counseling / psychotherapy. I understand that I am responsible for any amount not covered by insurance.

____
Client's Signature Date

COUNSELING CONCERNS

Why are you seeking help now?

____
____
____
____

What would you like to see happen as a result of counseling or psychotherapy?

____
____
____
____

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name ____ Physician's Phone # _________________________

Date of last physical _________________________

List physical illnesses or symptoms

____
____
____

List current medications

____
____
____

Psychiatrist's Name ____ Psychiatrist's Phone #_________________________

Have you received counseling or psychotherapy in the past? ❑Y or ❑N When? _________________________

With Whom? ____

Have you or any other family member received help for drug or alcohol dependency? ❑Y or ❑N

When? _________________________ Where?____

TREATMENT PLAN

(to be completed during the first session with your therapist)

Type of counseling: ❑Individual ❑Couple ❑Family ❑Group

Frequency of therapy: ____

Treatment Goals:

____
____
____
____
____
____

Referrals (specify):

____
____

____ ____

Client's Signature Date Therapist's Signature Date

____

Therapist's Credentials