CARE AND COUNSELING CENTER *of Georgia*

OFFERING HEALING, HOPE AND EDUCATION IN THE PASTORAL TRADITION

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Office Use Only
Client # ________________
Ins. Dx: ________________
Need Monthly Statement?
☐ Yes ☐ No
Therapist: ______________
Therapist # _____________
Center # _______________
EAP ☐ Yes ☐ No

CLIENT INTAKE INFORMATION FORM

Today's Date: ______________________

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: _______

	Preferred	***leave msg?***
Home Phone ______________________	☐	☐ Y ☐ N
Work Phone ______________________	☐	☐ Y ☐ N
Cell Phone ______________________	☐	☐ Y ☐ N

Email Address: ____

DOB: _____/_____/________ Age: _______ ☐ Male ☐ Female SSN: _______-_____-___________

Place of Employment: _______________________________________ Job Title: ______________________________________

Emergency Contact: ___________________________ Phone #: _______________________ Relationship: ____________________

Racial/ethnic identity: ☐ American Indian or Alaska Native ☐ Asian or Asian Indian ☐ Black or African-American ☐ Hispanic or Latino ☐ Middle Eastern ☐ Pacific Islander or Native Hawaiian ☐ White

Marital Status: ☐ Single ☐ Engaged ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner's Name: ____ # of years together: ______________________

Religious/Denominational Preference: ____

Referred by: ____ May we thank the person? ___ Yes ____No

INSURANCE INFORMATION (***if applicable***)

Policyholder's Name: ______________________________________ Policyholder's Employer: ______________________________

Street Address: ____ City: _______________________ State: ____ Zip: _______

Policyholder's SSN: _______-_____-_________ Policyholder's DOB: ___/___/___ Relationship to Client: ____________________

Primary Insurance Carrier: _____________________________ Street Address: ____

City:________________________ State:___ Zip: _____ Policy #: ___________________________ Group #: ___________________

Preauthorization Required? ☐ Y ☐ N Phone: ____________________________________

Secondary Insurance Carrier: _____________________________ Street Address: ____

City:________________________ State:___ Zip: _____ Policy #: ___________________________ Group #: ___________________

Preauthorization Required? ☐ Y ☐ N Phone: ____________________________________

Would you like to join our email list for upcoming workshops and groups? ☐ Yes ☐ No
(We respect your email privacy. You will not receive unsolicited marketing. We will not share, transfer, sell or rent your information.)
Revised 3/1/2010 *(The information requested in this form will be kept confidential.)*

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 ☐ Check if none

____

____

____

Current Medication Dosage Frequency Prescribing MD

____

____

____

Psychiatrist's Name: ____________________________ Psychiatrist's Phone: ____

Have you ever had counseling or psychotherapy in the past? ☐ Yes ☐ No

If yes, when? ______________________________ With whom? ______________________________________

Have you or any other family member received help for drug or alcohol dependency? ☐ Yes ☐ No

If yes, when? ______________________________ Where? __________________________________

Check which of the following you use, and note the amount and frequency of each:

☐ Caffeine: ___________________________________ ☐ Tobacco: ____

☐ Coffee ☐ Sodas ☐ Other drinks ☐ Pills

☐ Alcohol: ____________________________________ ☐ Marijuana: ______________________________________

☐ Cocaine, Crack: ______________________________ ☐ LSD: ____

☐ Inhalents: ___________________________________ ☐ Other: ____

Have you been concerned or ever felt guilty about your use of drugs/alcohol? ☐ Yes ☐ No

Has anyone ever expressed concern about your use of drugs/alcohol? ☐ Yes ☐ No If yes, who? ____________________________

Have you ever had a DUI? ☐ Yes ☐ No If yes, how many?_______ When? ____

Have you ever felt the need to cut down on your use of drugs/alcohol? ☐ Yes ☐ No

Have you or others ever felt annoyed by criticism of your use of drugs/alcohol? ☐ Yes ☐ No

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope with withdrawal symptoms? ☐ Yes ☐ No

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Checklist of Concerns

Please check any relevant concerns.

THOUGHTS/FEELINGS/MOOD

- ☐ Anger/frustration/hostility
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Confusion
- ☐ Depression
- ☐ Disliking others
- ☐ Emptiness
- ☐ Euphoria
- ☐ Excessive worry
- ☐ Failure
- ☐ Fatigue
- ☐ Fear
- ☐ Grieving (death, loss, divorce, etc)
- ☐ Guilt
- ☐ Hearing things other people don't
- ☐ Homicidal thoughts
- ☐ Intrusive thoughts
- ☐ Judgment problems
- ☐ Memory difficulties
- ☐ Negative thoughts
- ☐ Obsessive thoughts
- ☐ Oversensitivity to criticism
- ☐ Oversensitivity to rejection
- ☐ Panic attacks
- ☐ Perfectionism
- ☐ Sadness
- ☐ Seeing things other people don't
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Shyness
- ☐ Spiritual, religious, or moral issues
- ☐ Stress
- ☐ Sudden mood changes
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Thoughts of hurting self or others

BEHAVIOR

- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Argumentative
- ☐ Avoidant
- ☐ Compulsive behavior/rituals
- ☐ Controlling
- ☐ Decreased/lack of sexual interest
- ☐ Dependency
- ☐ Destruction of property
- ☐ Drug use – prescription, over-the-counter, street
- ☐ Eating problems
- ☐ Financial problems, debt
- ☐ Gambling
- ☐ Hyperactivity
- ☐ Internet problems
- ☐ Irresponsibility
- ☐ Isolation
- ☐ Legal problems
- ☐ Letting others take advantage of you
- ☐ Lying
- ☐ Not able to relax
- ☐ Pornography
- ☐ Preoccupation with sex
- ☐ Procrastination
- ☐ Purging
- ☐ Self destruction/sabotaging
- ☐ Self-neglect
- ☐ Sexual dysfunction
- ☐ Smoking
- ☐ Stealing
- ☐ Threats
- ☐ Weight, gain/loss
- ☐ Withdrawal from others
- ☐ Loss of interest on what I used to like
- ☐ Sleep difficulty
- ☐ Loss of appetite
- ☐ Overeating

FAMILY & RELATIONSHIPS

- ☐ Affair
- ☐ Childhood issues (your childhood)
- ☐ Divorce
- ☐ Friendships
- ☐ Housework/chores
- ☐ Interpersonal conflicts
- ☐ Parenting
- ☐ Problems with child(ren)
- ☐ Problems with parents
- ☐ Problems with spouse/partner
- ☐ Separation

ABUSE

- ☐ Abuse of alcohol
- ☐ Abuse of drugs
- ☐ Emotional abuse by another
- ☐ Emotional abuse of another
- ☐ Financial abuse
- ☐ Neglect
- ☐ Physical abuse by another
- ☐ Physical abuse of another
- ☐ Sexual abuse by another
- ☐ Sexual abuse of another
- ☐ Verbal abuse

WORK & SCHOOL

- ☐ Absenteeism
- ☐ Career concerns, goals, choices
- ☐ Difficulty with coworkers
- ☐ Difficulty with supervisor
- ☐ Performance
- ☐ Tardiness
- ☐ Procrastination
- ☐ School problems

OTHER CONCERNS

- ☐ ______________________________
  ____
- ☐ I have no problems or concerns bringing me here.

Revised 3/1/2010 *(The information requested in this form will be kept confidential.)*