Adult Client Intake Forms

CLIENT INFORMATION

Name:_____ Date of Birth:_____ Age:_____

Social Security Number:_____ Email: _____

Address:_____

City, State, Zip: _____

Phone 1:_____ Phone 2: _____

May we leave a voicemail message or send a text to Phone 1 and/or Phone 2? _____

How did you hear about Brave Tomorrow? _____

EMERGENCY CONTACT

In case of emergency, who may we notify? _____

Relationship to client:_____ Phone: _____

APPOINTMENT AVAILABILITY

Each session is 45 minutes in length. Please indicate with a check all times you are available for an appointment, and circle the times you prefer:

	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm
Mon.											
Tue.											
Wed.											
Thu.											
Fri.											

brave tomorrow
counseling & consulting

Telephone: (404) 620-1551
Fax: (888) 241-9172
Email: office@bravetomorrow.net
Address: 337 South Walnut Street
Statesboro, GA 30458

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Please list any medical problems: _____

Have you ever seen a Psychiatrist, Psychologist, or any other mental health provider? _____

If yes, please list name of provider and focus of treatment: _____

Previous Mental Health diagnoses: _____

_____

Please list any current medications: _____

_____

Have you ever been hospitalized for psychiatric reasons? If yes, please complete:

Hospital	Month/Year	Reason

EDUCATIONAL AND CAREER

Highest level of education completed: _____

If college or technical school, please list majors/areas of concentration and degrees obtained: _____

_____

Current Employment: _____

Which best describes your satisfaction with your current employment situation? (Check all that apply):

- ☐ I am very happy with my current position.
- ☐ I enjoy the work I do, but I would like to pursue a promotion and/or raise.
- ☐ I enjoy the type of work I do, but I am unhappy at my current place of employment.
- ☐ My employment is just a job – something that brings in money – not really something that I love.
- ☐ I would like to work toward a job that is a better fit for me.
- ☐ I am currently unemployed

FAMILY/RELATIONSHIP INFORMATION

Current Relationship Status (check any that apply):

- ☐ Currently married (how long? _____)
- ☐ Not married, but committed partner relationship (how long? _____)
- ☐ Previously married
- ☐ Living together
- ☐ Dating
- ☐ No significant other relationship at this time

Children:

Name	Age	Biological/Step	Lives With?

Any other people in the home:

Name	Age	Relationship

Have you been involved with Department of Family and Children's Services (DFCS) *in the past*? If so, please explain: _____

Are you *currently* involved with DFCS? If so, please explain: _____

Please list any significant family issues or concerns at this time: _____

SUBSTANCE USE

I use the following:	Never	Seldom	Often	Daily	For how long?
Alcohol					
Nicotine (Cigarettes, Tobacco, E-cigs)					
Marijuana					
Cocaine					
Pain Pills (with or without prescription), Methadone or Suboxone					
Heroin or other opiate					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Have you ever been in a support group (AA, NA, Celebrate Recovery) for alcohol or drug use (please explain)? _____

_____

Have you been in an outpatient treatment program for alcohol or drug use, DUI classes, or other drug classes (please explain)? _____

_____

Have you ever been hospitalized or in an inpatient treatment program for alcohol or drug use (please explain)? _____

_____

LEGAL INVOLVEMENT

In the past, have you been convicted of a crime (misdemeanor or felony)? If yes, please explain: _____

_____

Are you currently involved with the legal system in any way? (Awaiting trial, probation, parole, etc.)? If yes, please explain: _____

_____

MENTAL STATUS/SYMPTOM CHECKLIST

Please circle any of the following that describe how you have been feeling *lately*:

Sad	Anxious	Depressed	Frightened	Guilty	Angry	Ashamed	Aggressive	Worthless
Extreme Ups	Extreme Downs	Resentful	Tearful	Irritable	Confused	Jealous	Hopeless	Annoyed

Describe any other significant feelings you are having: _____

_____

Have you ever **considered or attempted** suicide in connection with current or past problems? If yes, please give a brief description with dates: _____

_____

Have you ever **considered or attempted** to hurt or kill someone else in connection with current or past problems? If yes, please explain: _____

_____

Have you engaged in self-harming behaviors (cutting, burning, etc) in connection with current or past problems? If yes, please explain: _____

_____

Please complete:

I AM EXPERIENCING/FEELING:	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias (unusual fear of specific things)					
Panic attacks (sweating, trembling, shortness of breath, rapid heartbeat)					
Recurring, distressing thoughts about a trauma					
"Flashbacks" – as if reliving traumatic event					
Avoiding people/places associated with the trauma					
Nightmares					
Difficulty falling asleep or staying asleep					
Frequent fatigue					
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					

I AM EXPERIENCING/FEELING:	Never	Seldom	Often	Always	For how long?
Obsessive thoughts					
Uncontrollable, repetitive behaviors					
Decreased interest in activities I usually enjoy					
Social isolation, lonliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Low self-esteem					
Angry, Irritable, Hostile					
Euphoric, energized, and highly optimistic					
Racing thoughts					
Needing less sleep than usual					
More talkative than normal					
Moods that go up and down					
Desire to engage in risk-taking activities (driving fast, skydiving, racing, etc)					
Making choices without concern for the consequences					
Hurting myself physically					
Violent behaviors toward others					
Restriction of my eating/food choices					
Binging and purging (in my food choices)					
Binge eating					
Significant weight loss or weight gain					
Concern about sexual activities					
Discomfort with sexual activities					
Questions about my sexual orientation					
Hearing voices even though no one nearby is talking to me					
Feeling controlled by forces outside of me					
Feeling that other people control my thoughts					
Feeling that someone is out to hurt me, or do something against me					

COUNSELING CONCERNS, RESOURCES, AND GOALS

What are the concerns that bring you to counseling?

1. _____
2. _____
3. _____
4. _____
5. _____

What have you previously tried in order to resolve these issues (religious counseling, talking with family/friends, medication without counseling, other counselors)? Were any of these helpful? _____

_____

Who do you consider your support system? _____

_____

How do you deal with stress in your life right now? _____

_____

What are your strengths? What do you do well? _____

_____

GOALS ARE VERY IMPORTANT IN COUNSELING. They provide the client and the therapist with a focus and a direction for therapy sessions. Please list the goals that you want to address and reach in counseling.

1. _____
2. _____
3. _____
4. _____
5. _____

By signing below, I confirm that the above information is true and correct. I understand that I have the right to agree to, or to refuse, mental health services from Brave Tomorrow Counseling and Consulting.

Client name (printed): _____ Date: _____

Client signature: _____

Counselor signature: _____ Date: _____

PLEASE READ THE FOLLOWING CAREFULLY
I understand that I am responsible for my own and/or my child's fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.
Client Signature: _____ Date: _____

I understand that as a courtesy to its clients Brave Tomorrow utilizes a reminder system for appointments. It is my responsibility to keep updated email and cell phone information on file. I understand that I will be charged for late cancel (less than 24 hours) or missed appointments WITH OR WITHOUT a reminder notification. It is MY responsibility to keep track of my appointments.
Client Signature: _____ Date: _____

I understand that I must be committed to attend my own sessions on a consistent basis, on time, in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform the therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if under the influence of alcohol or drugs, or in the possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from Brave Tomorrow Counseling and Consulting.
Client Signature: _____ Date: _____

It is in your best interest to know that therapists at Brave Tomorrow are not considered Forensic Psychologists and conducting witness/testimonial services or assessments are not in our area of expertise. If you have a suspicion that your case will be going to court or you need therapist testimony, please let us know and we will provide you with an appropriate referral source that can better meet your needs. If you require services for court, we recommend that you hire another mental health professional for that purpose. Should you subpoena a Brave Tomorrow therapist as a factual case witness or involve them in court related processes, you agree to pay out of pocket for the therapist's time involved. Court-related expenses cannot be billed to insurance.
Client Signature: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance

Company Name _____

Please Circle: HMO PPO Other Policy ID Number: _____

Group Number: _____ Behavioral Health Phone: _____

Name of Insured: _____ D.O.B.:_____

Relationship to Client: _____

Secondary Insurance Policy

Company Name _____

Please Circle: HMO PPO Other Policy ID Number: _____

Group Number: _____ Behavioral Health Phone: _____

Name of Insured: _____ D.O.B.:_____

Relationship to Client: _____

(ATTACH COPIES OF CARDS BELOW)

Client Agreement to Pay for Service

I agree to pay all charges for the services my child receives. If I use insurance to cover some or all of my child's counseling at Brave Tomorrow, I agree to pay any amounts that my insurance carrier does not pay. These may include (but are not limited to) services and charges determined by my insurance carrier not to be medically necessary, and/or services and charges not covered by my insurance plan. If I incur a charge for a missed or late-canceled appointment, I understand that I will be responsible for payment of that charge.

Client Signature: _____ Date: _____

SUMMARY OF CLIENT RIGHTS

When you receive mental health services, your rights are protected by the Health Insurance Portability and Accountability Act (HIPAA). Listed below is a simplified outline of those rights. The Notice of Privacy Practices describe any limitation to these rights and other provisions that may apply and should be consulted when there is a dispute or questions arise regarding any of these rights.

Your rights include:

- The right to receive care suited to your needs.
- The right to receive services that respect your dignity, and protect your health and safety.
- The right to know the names and positions of those involved in services planning and implementation process.
- The right to be informed of the benefits and risks of treatment.
- The right to participate in planning your own program.
- The right to refuse service, unless a therapist feels that refusal would be unsafe for you or others.
- The right to receive a copy of the Notice of Privacy Practices.
- The right to inspect and copy your records.
- The right to request amendment to your records.
- The right to request restriction or limitation on the medical information we use or disclose about you.
- The right to request how and where you may be contacted.
- The right to request on accounting of all disclosures we make about you to other persons or agencies.
- The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen.
- The right to remain free from physical restraints or time-out procedures unless such measures are required for providing effective treatment, or protecting the safety of you or others.
- The right to be free of physical or verbal abuse.
- The right to file a complaint if you think any of these rights have been restricted or denied.

You must be provided with a Notice of Privacy Practices that provides detailed information regarding your rights under HIPPA.

The client has had an opportunity to read, or have read to him/her, the above form to ask questions regarding the data contained therein and had signed in the person's presence.

Client Name: _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

SUMMARY OF CLIENT RIGHTS (CLIENT COPY)

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----------THIS COPY IS YOURS TO KEEP----------