Family Resource Center
Thriving Families. Nurtured Children.

122 North Laurel Drive, Clarksville, GA 30523 Office: 706-778-3100 - Fax: 706-928-5183

ADULT INTAKE INFORMATON

This Form is Confidential

Name ____ Birth Date ______________________

Age _________ Email Address: ____

Home Address ______________________________________ City _________________ Zip ______

Best contact number: ____ ____Cell ____Home

May we leave a voice or text message? ____Yes ____No

Employer ____ Occupation ___________________

Employer Address ____________________________________ City ________________ Zip ______

Highest Education Completed (Circle): Some High School, High School Diploma, Some College, Technical School, Associates Degree, Bachelors Degree, Graduate school or higher.

Who referred you to this office? ____

If referred by a doctor or other clinician would you like for us to communicate with them? ____Yes____No

Emergency Contact Name ________________________________ Phone________________________

Relationship: ____

Medical History

Approximate Height: ___________ Weight: __________ Gender: ________

Briefly describe your diet and exercise patterns:

____

____

Do you smoke or use tobacco? ____Yes ____No If yes, how much per day? _____________________

Do you consume caffeine? ____Yes ____No If yes, how much per day? _________________________

Do you drink alcohol? ____Yes ____No If yes, how much per day? ______________________________

Do you use any non-prescription drugs? ____Yes ____No If yes, how much per day?

____

Have any of your friends or family members voiced concern about your substance use? ____Yes ____No

If yes, why?____

Have you ever been in trouble or risky situations because of your substance use? ____Yes ____No

Are you Disabled? ____Yes ____No If yes please describe:

____

Please explain any medical problems, symptoms or illnesses:

____

____

Previous medical hospitalization approximate dates and reasons:

____

____

Previous psychiatric hospitalization approximate dates and reasons:

____

____

Please list current medications (list any additional medications on the back of this form if needed)

Name of Medication	Dosage	Purpose	Prescribing Doctor

Counseling Questions

Have you ever previously received counseling or consulted with a psychiatrist, psychologist or other mental health professional for services? ____Yes ____No

If yes, please describe approximately when and why services were obtained.

____

____

Did you find counseling helpful for you? ____

Why was prior counseling terminated or ended?

____

____

Please describe your reasons for your visit today.

____

____

What are your goals for therapy?

____

____

How long do you expect to be in therapying order to accomplish these goals?

____

____

Mental Health Symptoms

Please indicate any symptoms past & present on a scale from 0 (never) to 5 (all the time/severe):

DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past
Depression			Anxiety			Intense Fears		
Feeling Hopeless			Irritability			Nightmares		
Loss of Interest			Agitated/Restless			Feeling Numb/Detached		
Sleep too much			Fidgety			Easily Startled		
Sleep too little			Angry/Resentful			Obsessive Thoughts		
Excessive weight gain			Argumentative			Repetitive Behaviors		
Excessive weight loss			Dizziness			Overly Stressed		
Low Energy/Fatigue			Headaches			Sexual Concerns		
Memory Loss			Shortness of Breath			Domestic Violence		
Poor Concentration			Chills or Hot Flashes			Legal Problems		
Social Isolation			Heart Racing/Chest Pain			Financial Problems		
Grief			Muscle Tension			Drug Use		
Mood Swings			History of Head Injury			Alcohol Use		
Episodes of Crying			Blackouts			Chronic Pain		
Thoughts of Death			Completing Tasks			Problems at Work		
Self-Mutilation/Harm			Hyperactive			Problems at Home		
Suicide Attempt			Paying Attention			Problems with Friends		
Thoughts of Hurting Someone Else			Easily Distracted by Noise			History of Abuse/Neglect		

Family Relationships, Social Support and Self Care

Mother's age (or age at death) _______ How would you describe your relationship with your mother?

____

____

Father's age (or age at death) ______ How would you describe your relationship with your father?

____

____

If alive, are your parents still married? ____Yes ____No If they are divorced how old were you when they separated or divorced and how did this impact you?

____

____

Were there any other primary care givers who you had a significant relationship with? If so please describe who and how this person impacted your life:

____

____

How many sisters do you have? ______ List names and ages:

____

____

How many brothers do you have? ______ List names and ages:

____

____

How would you describe your relationship with your siblings?

____

____

Briefly describe any history of abuse, neglect and/or trauma:

____

____

____

Please indicate if there is a family history of any of the following (if there is, indicate the family member's relationship to you: for example, father, grandmother, brother etc.) Alcohol/substance abuse, anxiety, bipolar disorder, adoption, depression, domestic violence, foster care, eating disorders, hyperactivity, learning disabilities, legal trouble, "nervous breakdown", obesity, obsessive compulsive behavior, sexual abuse, schizophrenia, suicide attempts, trauma, or other.

____

____

____

Are you currently in a relationship? ____Yes ____No If yes for how long? ____

Married/Life Partner? ____Yes ____No If yes for how long? ____

Satisfaction with current relationship? (1 to 5 with 1 = lowest and 5 = highest) 1 2 3 4 5

Occupation of partner ________________________________ Employer____________________________

Previously Married/Life Partnered? ____Yes ____No

If yes, length of previous relationship ____

Do you have children ____Yes ____No If yes list names and ages:

____

____

Describe any problems any of your children are having.

____

____

____

List the names and ages of anyone currently living in your household.

____

____

____

What is your current level of satisfaction with friends and any social supports?

(1 to 5 with 1 = lowest and 5 = highest) 1 2 3 4 5

Please list the names of those who you would consider your close friends and can lean on in times of distress.

____

____

What are some of your strengths?

____

____

____

Is spirituality important in your life? ____Yes ____No Please explain:

____

____

Is there anything else you would like to share or feel your counselor should know about you and/or your circumstances before you begin working together? Please specify:

____

____

____

____

____

If involved with other agencies, please complete below.

Please provide information for the agencies you give permission to PCAH & your counselor to release information on the client's behalf, during the course of treatment.

Agency	Caseworker Name & Contact Information
Law Enforcement	
DFCS	
Guardian Ad Litem	
Attorney	
Circle of Hope	
Other	

I give permission to my counselor and PCAH to release information to the above listed agencies during my treatment. I also give these agencies permission to share information with PCAH and my counselor during my treatment.

____Yes ____No

Signature:____ Date: _____________

Client Agreement for Acceptance of Services

By initialing and signing below you agree with all the terms and services provided by the ***Counseling Program*** of the Family Resource Center-Prevent Child Abuse Habersham.

Policies and Procedures:

________ Please initial that you have read the policies on appointment cancellations and the procedures for contacting your therapist in the *Welcome Packet (pg. 1).*

________ Please initial if you have been informed on the location of the HIPPA *Notice of Privacy Practices* at the Family Resource Center Annex.

________ Please initial here if you have read the emergency services phone numbers in the *Welcome Packet (pg. 2) .*

Litigation Policy:

I understand that the Family Resource Center and all its contracted therapists are not custody evaluators and cannot make any recommendations on child custody cases *(pg. 3 of the Welcome Packet).* I also understand that in the event the Family Resource Center's policy regarding subpoenas and court appearances is disregarded *(or waived– even by the court),* I will be billed for the FULL STANDARD FEE for all court-related work: $400/hour for all professional time. This includes preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance, and any time spent waiting at the court house in addition to time on the stand, as well as any travel time etc.

____

↑ Print Client's Name ↑

____ Date: ____/____/____

↑ Signature of Client, Parent, Guardian or Personal Representative ↑

____ Date: ____/____/____

↑ Signature of Therapist ↑

Consent for Treatment

Your signature below indicates that you have read and understand the information as stated in the *Welcome Packet* and that by this consent form you give permission to the Family Resource Center to provide counseling services. This contract is binding for all future sessions you may have with this entity.

____ Date: ____/____/____

↑ Signature of Client, Parent, Guardian or Personal Representative ↑

____

If you are signing as a personal representative of an individual, please describe (above ↑) *your authority to act for this individual (parent, guardian, power of attorney, healthcare surrogate, etc.).*