Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

5855 Jimmy Carter Blvd., Suite 240, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

ADULT HISTORY- INTAKE FORM

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Address: _____

Telephone: _____ In case we need to call you, can we leave a message? Yes [ ] No [ ]

Person to contact in case of emergency: _____ Phone: _____

How long have you been living in the United States? _____ How long in the State of Georgia? _____

Do you speak any other languages? _____ Referred by: _____

I- CURRENT PROBLEM

What problem motivated you to seek help? Why were you referred? Please, describe

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What have you attempted to resolve your concerns? What has worked? What has not worked?

_____
_____
_____
_____
_____

II- CURRENT SYMPTOMS/COMPLAINTS CHECKLIST

	None	*Mild*	*Moderate*	*Severe*
Aggressive behaviors	[ ]	[ ]	[ ]	[ ]
Anorexia	[ ]	[ ]	[ ]	[ ]
Anxiety-Stress	[ ]	[ ]	[ ]	[ ]
Appetite disturbance	[ ]	[ ]	[ ]	[ ]
Binging or purging	[ ]	[ ]	[ ]	[ ]
Conduct problems	[ ]	[ ]	[ ]	[ ]
Depressed mood	[ ]	[ ]	[ ]	[ ]
Grief	[ ]	[ ]	[ ]	[ ]
Guilt	[ ]	[ ]	[ ]	[ ]
Hallucinations	[ ]	[ ]	[ ]	[ ]
Helplessness	[ ]	[ ]	[ ]	[ ]
Hopelessness	[ ]	[ ]	[ ]	[ ]
Hyperactivity	[ ]	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]	[ ]
Laxative or diuretic abuse	[ ]	[ ]	[ ]	[ ]
Loneliness	[ ]	[ ]	[ ]	[ ]
low energy	[ ]	[ ]	[ ]	[ ]
Mood swings	[ ]	[ ]	[ ]	[ ]
Nervousness	[ ]	[ ]	[ ]	[ ]
Obsessions or compulsions	[ ]	[ ]	[ ]	[ ]
Panic attacks	[ ]	[ ]	[ ]	[ ]
Paranoid ideation	[ ]	[ ]	[ ]	[ ]
Phobias	[ ]	[ ]	[ ]	[ ]
Poor concentration-memory	[ ]	[ ]	[ ]	[ ]
Restless-Increased energy	[ ]	[ ]	[ ]	[ ]
Sexual dysfunction	[ ]	[ ]	[ ]	[ ]
Significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
Sleep disturbance	[ ]	[ ]	[ ]	[ ]
Social isolation	[ ]	[ ]	[ ]	[ ]
Somatic complaints	[ ]	[ ]	[ ]	[ ]
Substance/ Drugs/ Alcohol use/ abuse	[ ]	[ ]	[ ]	[ ]
Suicide ideas	[ ]	[ ]	[ ]	[ ]
Thoughts about harming someone	[ ]	[ ]	[ ]	[ ]
Trauma perpetrator	[ ]	[ ]	[ ]	[ ]
Trauma victim	[ ]	[ ]	[ ]	[ ]
Worthlessness	[ ]	[ ]	[ ]	[ ]

III- FAMILY HISTORY

Marital Status: [ ] Separated [ ] Single [ ] Partnered [ ] In a relationship [ ] Divorced [ ] Married [ ] Widowed

Name of spouse or partner (if applicable): _____Age: _____ Originally from? _____

Dating since? _____ Date of marriage or started living together: _____

If you ever lived with an ex partner or ex-spouse, how long did that relationship last? _____

Did you have children in a previous relationship? [ ] Yes [ ] No How many?_____

List the following information about your children in your current or previous relationship. If your spouse has children from a previous relationship, please include their names in this list:

Name	***Sex***	***Age***	***Biological or Adopted***	***Living with you?***	
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No

List any other family members / friends living with you: _____

IV- EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy or counseling? [ ] Yes [ ] No If yes, specify length of treatment and time period below.

Prior inpatient treatment for a psychiatric, emotional or substance use disorder? [ ] Yes [ ] No

If yes, specify length of treatment and time period below.

_____

_____

Prior or current psychotropic medication usage? [ ] Yes [ ] No If yes, please specify:

_____

Prior psychological evaluations? [ ] Yes [ ] No If yes, when and why:

_____

Suicide or Homicidal ideations:

If history is positive for suicide or homicidal ideation / attempts, please describe incident and date:

_____

V- MEDICAL HISTORY

Describe current physical health / Current or past serious medical problems:

_____

_____

Describe history of head injuries or other neurological problems and the consequences: _____

_____

Describe past major surgical history: _____

List current medication: _____

_____

VI- SUBSTANCE USE HISTORY

[ ] I don't use alcohol or drugs. *Please continue with the next section*

If the answer is affirmative, please describe your use of alcohol or drugs.

Current Substance Use Status: _____

Consequences of substance use: _____

VII- EDUCATIONAL HISTORY

List your highest grade in school or college / degree achieved and where you got it.

_____

VIII- OCCUPATIONAL HISTORY

Adult jobs (responsibilities, full time or part time, how long)

_____

_____

IX- CURRENT & PAST LEGAL HISTORY

Any past arrests or legal problems? Describe, please: _____

_____

X- SOCIO-ECONOMIC HISTORY

Living situation: _____

Daily activities: _____

Financial situation: _____

Social / Family support system: _____

Spiritual or religious practice: _____

Recreational/ hobbies, interests & leisure activities: _____

_____

XI- DEVELOPMENTAL HISTORY

List any problems during birth, delivery, childhood, adolescence: _____

_____

List what best describes your childhood

____ Emotional problems
____ Drug abuse
____ Medical problems
____ Witnessed domestic violence between parents
____ Physically abused
____ Sexually abused
____ Other problems: _____
____ Eating disorders
____ Problems in school
____ Family problems
____ Legal problems
____ Behavioral problems
____ Alcohol abuse
____ No major issues during my childhood

Additional Information:

Anything else about your case you would like to mention or emphasize? [ ] Yes, describe [ ] No

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AUTHORIZATIONS

Verification of Information

My signature means that I am providing the information related to my case. I affirm that all the information that I have provided and that the evaluator/ counselor has obtained is true and correct. I am the only one responsible for providing the information contained in this clinical history.

Confidentiality

This is a strictly confidential patient/ examinee or client mental health record. Redisclosure or transfer without the client's or examinee written consent is strictly prohibited, except as permitted by the law.

Authorization for release of information

If my case is of a legal nature, I authorize the release of information related to my case to my probation or parole officer, my attorney or legal counsel, the court and its agents, DFCS, or any other agency or entity legitimately related to my case. I will be informed by my therapist in case of any request for information.

_____ _____
Client's signature *Date*

_____ _____
Therapist or Examiner *Date*

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INFORMED CONSENT FOR COUNSELING SERVICES

Welcome to the Counseling Institute of Atlanta, Inc, for Counseling Services. Thank you for trusting us to assist you with your concerns. It is our desire to help you in this moment of your life. We are honored that you have chosen us as your therapist. We will do everything we can to help you move forward and solve your problems.
Please take the time to complete this form, make sure you read and understand this document. If you have any questions, do not hesitate to ask your therapist/ counselor.

LIMITATIONS OF SERVICES: I understand that the Counseling Institute of Atlanta, Inc.'s services are limited to counseling services including assessment, consultation, therapy, and intervention. Assessment services may include the use of questionnaires or tests which may be used to inform intervention services such as counseling and psychotherapy or to provide recommendations. I understand that my therapist is not warranting a cure or offering any guarantee of results or improvement of any condition.

SERVICE SATISFACTION/ RESEARCH: I understand that the Counseling Institute of Atlanta, Inc.'s may occasionally collaborate with colleges and universities to provide training to masters and doctoral level students by serving as a practicum/internship site. All interns are supervised by senior level staff (Licensed Professional Counselor, Licensed Clinical Social Worker, Psychiatrist or Licensed Psychologist). If you prefer not to work with a graduate trainee, please speak with your therapist or the receptionist. The Counseling Institute of Atlanta, Inc's may also at times collect information about your experiences in treatment to inform and potentially improve our ability to deliver high quality services. As part of this effort we may ask clients to complete a brief evaluation, survey, or questionnaire on a voluntary and anonymous basis. If you have any questions please speak with your therapist or the receptionist.

ASSUMPTION OF RISKS: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. Your active participation and commitment are important during this process. Some people may need a few sessions and others may need more. Come to our office on time according to your scheduled appointment. If for any reason, you are not able to attend, please let us know in advance so we can use that time with another client.
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.
I understand that the potential benefits of undergoing counseling services may include obtaining professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of mental health assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation.

LIMITS OF CONFIDENTIALITY: I understand that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions listed below. I understand that confidential and privileged information may be released without my consent or authorization for the following purposes: (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm (4) to obtain payment for services, in which instance the disclosure is limited to the minimum that is necessary to achieve the purpose. I hold the provider harmless for releasing information under any of the above conditions.
To release information about your therapy, we need to have written releases from you. In general, the law protects the confidentiality of all communications between clients and counselors. We only release information about our work with your written releases. Clients often give me releases to talk to their individual therapists, and/or previous therapists. This helps us to coordinate your therapy so that it will be most helpful to you.

There are also a few situations in which we are legally required to protect someone, even if that involves revealing some information about a client's treatment:

1. If we believe that a child, an elderly person or a disabled person is being abused, we may be required by law to file a report with the appropriate state agency.
2. If we believe that a client of mine is threatening serious bodily harm to another person, we may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
3. If a client of ours threatens to harm him/herself, we may be required to seek hospitalization for that client, or contact family members or others who can help provide protection.

Occasionally, we find it helpful to consult with other professionals about a situation in therapy. In these consultations, we avoid revealing the identity of my clients. We will usually inform you of these consultations.

STATEMENT OF UNDERSTANDING: I understand the above information and/or have discussed any questions related to the above information to my satisfaction. By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

Client's Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT

My signature acknowledges that I have received a copy from the Counseling Institute of Atlanta, Inc. of the Notice of Policies and Practices to Protect the Privacy of Your Health Information. This notice details the policies that protect the privacy of my personal health information.

I consent to the use and disclosure of my protected mental health information by the Counseling Institute of Atlanta, Inc. for the purpose of providing treatment to me, obtaining payment for the mental health services provided, and/or to conduct other counseling services.

I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with the staff of the Counseling Institute of Atlanta, Inc.

Client's Signature: _____ Date: _____

Client's Name: _____ Date of Birth: _____

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CANCELLATION AND MISSED APPOINTMENT POLICIES

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed a full session fee for your missed appointment.

You will be automatically charged a full session fee for any missed appointments that are cancelled with less than 24-hour notice. This fee may be waived in cases involving emergencies, but such a waiver is solely at our discretion. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment on time.

Thank you for understanding and cooperation.

The signature below acknowledges that I understand and accept the terms and conditions of this policy.

Client's Signature: _____ Date: _____