



**II- CURRENT SYMPTOMS/COMPLAINTS CHECKLIST**

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

**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:

<i>Name</i>	<i>Sex</i>	<i>Age</i>	<i>Biological or Adopted</i>	<i>Living with you?</i>	
				yes	No
				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: \_\_\_\_\_





**Counseling Institute of Atlanta, Inc.**  
Bilingual & Multicultural Mental Health Services

**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.

The client understands that secure and private communication cannot be completely guaranteed through cellphones and e-mail. It is the decision of the client to communicate, or not, through these “non-secure” technologies. If the client uses these “non-secure” technologies to contact the counselor, the counselor will communicate with the client through these “non-secure” technologies as well, until the client indicates otherwise. Please, indicate what type of communication is allowed:

Communication via phone or cell phone _____	Communication via voice message _____
Communication via fax _____	Communication via e-mail _____
Communication via text message _____	Communication via teleconference _____

**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*



# Counseling Institute of Atlanta, Inc.

## Bilingual & Multicultural Mental Health Services

### 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.

**TERMINATION OF THERAPY:** Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. The staff from the Counseling Institute of Atlanta, Inc., will try to contact you, but your case will be terminated/closed if we do not hear back from you. If you are feeling better or planning not to return to therapy, it is important that you come in for a final session, so that we can discuss the reasons leading to the decision, the course of therapy and any relevant referrals. A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan.

**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: \_\_\_\_\_