Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services
5855 Jimmy Carter Blvd., Suite 200, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

TELEMENTAL HEALTH COUNSELING - Intake Form

I. CLIENT'S INFORMATION

Name: ____Date: ______________

Age: __________ Date of birth: __________ Place of origin: ______________________

Address (please include city and country): ______________________________

How much time have you been living in the United States? ______________________

Phone number: ____________________ e-mail: ______________________

Referred by: ____

II. LOCAL RESOURCES

1. Person to contact in case of emergency (1): ______________________________

Relation: ____________________ Phone number: ______________________

Address (please include city and country): ______________________________

e-mail: ____

Comments: ____

2. Person to contact in case of emergency (2): ______________________________

Relation: ____________________ Phone number: ______________________

Address (please include city and country): ______________________________

e-mail: ____

Comments: ____

3. Name of your counselor (if applicable): ______________________________

Address (please include city and country): ______________________________

Phone number: ____________________ e-mail: ______________________

Comments:____

____

4. Name of your psychiatrist (if applicable): ____________________

Address (please include city and country): ____________________

Phone number: ____________________ e-mail: ____________________

Comments: ____________________

5. Name of your physician: ____________________

Address (please include city and country): ____________________

Phone number: ____________________ e-mail: ____________________

Comments: ____________________

6. Name of the nearest hospital: ____________________

Address (please include city and country): ____________________

Phone number: ____________________ e-mail: ____________________

Comments: ____________________

7. Nearest mental health clinic: ____________________

Address (please include city and country): ____________________

Phone number: ____________________ e-mail: ____________________

Comments: ____________________

8. Nearest psychiatric clinic: ____________________

Address (please include city and country): ____________________

Phone number: ____________________ e-mail: ____________________

Comments: ____________________

9. DFCS local phone number: ____________________

10. Nearest Police Department: ____________________

Phone number: ____________________

III. FAMILY HISTORY

Marital status: [ ] separated [ ] single [ ] partnered [ ] in a relationship [ ] divorced

[ ] married (1st marriage) [ ] married (after being divorced, separated or widowed) [ ] widowed

Name of your current partner: ____

Age: ____________ Country and city of origin: ________________________________

Length of relationship: __________________ Date of marriage: ___________________

Number of children with your current partner: ______________________________

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

Did you have children with your previous partner? [ ] Yes [ ] No How many? ______________

List the following information about your children with your current partner and if you had any children with your previous partner. If your current partner has children from a previous relationship, please mention them too.

Name	Sex	Age	Biological or adopted	Does he/she live with you?

IV. CURRENT PROBLEM

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

____

____

What did you try to do before to solve your problem? What worked? What did not work?

____

____

V. MEDICAL HISTORY

List your current physical health [ ] poor [ ] not satisfactory [ ] good [ ] very good

Please, mention your current health problems:

____

____

Describe past or current serious medical problems, history of head injuries, or other neurological problems:

____

____

List current medication, since when you are taking them, and their names

____

____

VI. CURRENT SYMPTOMS/ COMPLAINTS CHECKLIST

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

VII. EMOTIONAL/ MENTAL HEALTH TREATMENT HISTORY

Prior outpatient psychotherapy or counseling? [ ] Yes [ ] No

If "Yes", specify length of treatment and time period below:

____

____

Have you ever had suicidal ideation/ attempts? [ ] Yes [ ] No If "Yes", please describe:

Have you ever had ideation/ attempts to hurt someone? [ ] Yes [ ] No If "Yes", please describe:

____

____

VIII. SUBSTANCE USE HISTORY

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

[ ] I do use alcohol or drugs.

If the answer is affirmative, please answer:

Describe your use of alcohol and drugs:

____

____

Consequences of substance abuse:

____

____

Any past treatment for substance use:

____

____

IX. EDUCATIONAL HISTORY

List highest grade/ degree achieved: ____

X. OCCUPATIONAL/ EMPLOYMENT HISTORY

Current job and previous job (responsibilities, part time or full time):

____

____

XI. LEGAL HISTORY

Have you ever been arrested? Have you ever had problems with the law? Please, describe:

____

____

XII. SOCIO-ECONOMIC HISTORY

Living situation (house, apartment, trailer- rent or own): ________________________________

Daily activities: ____

Financial situation: ____

Social/family support system (people who live with you and family who lives near you):

____

Spiritual or religious practice: ____

Recreational activities, hobbies, interests: ____

XIII. DEVELOPEMENTAL HISTORY

List any problems during birth, delivery, childhood, and/ or adolescence:

____

List what best describes your childhood:

____ Emotional problems
____ Drug abuse
____ Medical problems
____ Witnessed domestic violence
____ Physically abused
____ Sexually abused
____ Eating disorders
____ School problems
____ Family problems
____ Legal problems
____ Behavioral problems
____ Alcohol abuse
____ No major problems in my childhood
_____ Happy childhood
____ Other problems: ______________________

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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 examiner 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 client mental health record. Re-disclosure or transfer without the client's 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 fax ___________
Communication via text message ___________
Communication via voice message ___________
Communication via e-mail ___________
Communication via teleconference ___________

Authorization for release of information

Only if my case is of a legal nature, I authorize the release of information related to my case to my probation and 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/counselor in case of any request for information.

My signature below acknowledges that I understand and accept the terms and conditions of this authorization and agreement.

______________________________________ ____________________________
Client's signature Date

______________________________________ ____________________________
Therapist or Examiner's Signature Date

Counseling Institute of Atlanta, Inc.

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INFORMED CONSENT FOR TELEMENTAL HEALTH COUNSELING

Welcome to the Counseling Institute of Atlanta, Inc, for counseling/psychotherapy/mental health evaluation 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.

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.

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.

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 (LPC, LCSW, 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.

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, I need to have written releases from you. In general, the law protects the confidentiality of all communications between clients and counselor. I 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 me 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 mine 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.

ADDITIONAL POINTS FOR CLIENT'S UNDERSTANDING:

- I understand that TeleMental Health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the TeleMental Health sessions will be recorded or photographed without my written permission.
- I understand that, because this is a technologically based method, sometimes it may be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand that TeleMental Health is done over a secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality.
- My counselor has explained to me how the video conferencing technology and telephone procedures will be used. I understand that TeleMental Health sessions will not be exactly the same as in person sessions due to the fact that I will not be in the same room as my counselor.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my counselor or I can discontinue the TeleMental sessions if it is felt that the videoconference or telephone connections are not adequate for the situation.
- I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.
- I understand that I may experience benefits from the use of TeleMental Health in my care, but that no results can be guaranteed or assured.
- I understand that if there is an emergency during the TeleMental Health session, my counselor will call emergency services and my emergency contacts.
- I understand that if the video conferencing or telephone connection drops while I am in a session, that I will have a phone line available to contact my counselor.
- I understand that I will create a safety plan with my counselor in case of an emergency.

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 was informed and 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 printed 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 48-hour notice. A bill will be mailed directly to all clients who do not show up for the appointment 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: __________________________