

# Adult Intake Form

237 Taconic Road, Greenwich, CT 06831

FAX: 203 340 9815

## GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone (h) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone (w) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Phone (cell) \_\_\_\_\_

For confidentiality, when and where do you prefer to be reached? \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current marital status:  Single  Engaged  Married  Separated  Divorced  Widowed

Date of Current Marriage/Separation: \_\_\_\_\_ Number of Marriages: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Number of Children and ages: \_\_\_\_\_

Presently living with:  Parents  Spouse  Roommate  Alone  Other

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to you \_\_\_\_\_

Who referred you or how did you hear about us? \_\_\_\_\_

Counselor Preference (if none, leave blank): \_\_\_\_\_

## Please specify days/times for your appointment availability:

*Monday:*  morning  afternoon  evening  
*Tuesday:*  morning  afternoon  evening  
*Wednesday:*  morning  afternoon  evening  
*Thursday:*  morning  afternoon  evening  
*Friday:*  morning  afternoon  evening

## What type of counseling are you seeking? Please select one:

Type	Description	Forms Required
<input type="radio"/> Individual	1 on 1 Counseling	1 intake form per person
<input type="radio"/> Family	2 or more Family Members	1 intake form per person over 18 yrs
<input type="radio"/> Relationship	Couples who are dating	1 intake form per person (2 forms total)
<input type="radio"/> Pre Marital	Couples engaged or considering it	1 intake form per person (2 forms total)
<input type="radio"/> Marital	Couples needing marital guidance	1 intake form per person (2 forms total)

## Reasons for seeking help

What concerns have led you to pursue counseling? \_\_\_\_\_

Where are your concerns causing the most problems for you? Check all that apply:

Home  Work  Marriage  Other Relationships  God

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When did your present concern begin to be a problem for you? \_\_\_\_\_

Have any concerns about you been identified by others? \_\_\_\_\_

Please rate the severity of your present concerns on the following scale. Check one:

- Mild     Moderate     Severe     Totally Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply:

- |   |   |
|---|---|
| <input type="radio"/> Under too much pressure/feeling stressed    | <input type="radio"/> Insomnia (no sleep) or Hypersomnia (sleep all the time) |
| <input type="radio"/> Excessive anxiety or worry                  | <input type="radio"/> Loss of appetite/increased appetite                     |
| <input type="radio"/> Feeling lonely                              | <input type="radio"/> Lacking self-confidence                                 |
| <input type="radio"/> Angry feelings                              | <input type="radio"/> Issues with food and/or weight                          |
| <input type="radio"/> Concerns about finances                     | <input type="radio"/> Abuse of alcohol and/or non-prescription drugs          |
| <input type="radio"/> Feeling "numb" or cut off from emotions     | <input type="radio"/> Delusions   |
| <input type="radio"/> Angry outbursts                             | <input type="radio"/> Feeling distant from God                                |
| <input type="radio"/> Excessive fear of specific places/objects   | <input type="radio"/> Hallucinations  |
| <input type="radio"/> Difficulty making friends                   | <input type="radio"/> Inability to concentrate while at school/work           |
| <input type="radio"/> Feeling as if you'd be better off dead      | <input type="radio"/> Crying spells   |
| <input type="radio"/> Feeling that people are "out to get you"    | <input type="radio"/> Nightmares  |
| <input type="radio"/> Feeling manipulated or controlled by others | <input type="radio"/> Loss of interest in usual activities/lack of motivation |
| <input type="radio"/> Difficulty making decisions                 | <input type="radio"/> Obsessions or compulsions with specific activities      |
| <input type="radio"/> Loss of interest in sexual relationships    | <input type="radio"/> Inability to control thoughts                           |
| <input type="radio"/> Concerns about physical health              | <input type="radio"/> Feeling trapped in rooms/buildings                      |
| <input type="radio"/> Blackouts or temporary loss of memory       | <input type="radio"/> Hearing voices  |

## MEDICAL/HEALTH INFORMATION

- Good     Fair     Poor

Date of last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems)     Yes     No

If yes, please explain: \_\_\_\_\_

Medication(s) Over-the-counter or prescription	Dosage

Previous hospitalizations for medical reasons: Date \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Reason \_\_\_\_\_

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## COUNSELING HISTORY

Please list names of any previous counselors or therapists, including dates and contact numbers:

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How do you feel about the results of your previous counseling? \_\_\_\_\_

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Permission to contact previous counselor:     Yes     No

Have you ever been hospitalized for psychiatric purposes?     Yes     No

If yes, please explain including name of hospital, location and dates:

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What do you hope to gain from counseling? \_\_\_\_\_

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## OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

If Currently a Student: Field of Study \_\_\_\_\_     Part-Time     Full-time

University or College \_\_\_\_\_

## Religious Background (optional)

Do you believe in God?     Yes     No    Religious preference: \_\_\_\_\_

What house of worship do you currently attend? \_\_\_\_\_

How much influence does your religion have on your day-to-day activity? \_\_\_\_\_

Are clergy providing you with pastoral support? \_\_\_\_\_

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## COUNSELING AGREEMENT

In the interest of full disclosure about the counseling you will be receiving, please read through this following agreement, sign and date it at the bottom. This form must be signed and included with the intake form in order to begin counseling.

### Description of Counseling

Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. Each of our counselors adheres to the code of ethics prescribed by his/her respective professional body.

### Referral Policy/Disclaimer

Clients will be referred outside when treatment required is beyond the scope of care available here. Though we strive to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. We are not liable for any services provided or not provided by the referred professional.

### Counseling Fees

Fees are for 50-minute sessions and payment is due at the beginning or the end of each session. Accounts must be kept current in order to continue counseling. Cash or checks are accepted forms of payment to GCHR.

\*\*\*Please note that we are unable to accept insurance. However, we provide clients with receipts for reimbursement of out-of-network insurance benefits. Because insurance plans vary, please first check with your insurance provider to see if you have out-of-network benefits and whether you will qualify for reimbursement.\*\*\*

### Confidentiality

To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent. Please see the "HIPAA: Notice of Policies and Practices to Protect the Privacy of Your Health Information" given to you at your initial session for details. All counselors participate in regular peer supervision. During this supervision your personal identity will be concealed. The purpose of supervision is to ensure quality of care.

### Rights As a Client

1. You are entitled to information about any procedures, methods of counseling, techniques, and possible duration of counseling.
2. You have the right to end counseling at any time without any moral, legal, or financial obligations other than those already accrued.
3. You have the right to expect confidentiality within the limits described in the "HIPAA: Notice of Policies and Practices to Protect the Privacy of Your Health Information".
4. You have the right to request in writing the release of your records to any person or agency.
5. You have the right to authorize your counselor to consult with another professional about your counseling in writing.
6. You have the right to file a grievance in writing with the Director if you have concerns that your rights as a client have been violated.

### Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the counselor and client. The cost of such mediation, if any, shall be shared equally.

### Cancellation Policy

We request that you notify your Counselor at least **24 hours** before your scheduled appointment time if you need to cancel a session. *Failure to do so will result in charges for the missed appointment.* This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for emergencies only.

### Contacting Your Counselor

For scheduling and canceling your appointments, you must contact your counselor directly. For general information, please contact the reception desk during regular offices hours of 9:00 AM - 5:00 PM. For emergencies after-hours, please contact 911 or your local emergency room.

If these guidelines are acceptable to you, please sign below:

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

(Required if under the age of 18)