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

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

Type	Description	Forms Required
○ Individual	1 on 1 Counseling	1 intake form per person
○ Family	2 or more Family Members	1 intake form per person over 18 yrs
○ Relationship	Couples who are dating	1 intake form per person (2 forms total)
○ Pre Marital	Couples engaged or considering it	1 intake form per person (2 forms total)
○ 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:

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

_____

_____

_____

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

_____

_____

_____

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:

_____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

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.

Therapist cannot be called as a witness or an expert in any situation or arbitration. You agree to defend me from any subpoenas from third parties relating to the subject matter of your counseling session.

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)