new hope
counseling services

Date: _____

Adult Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred you? _____

What would you like to see happen as a result of counseling?_____

Are you seeking disability due to your current mental/emotional health? ☐ Y ☐ N

Are you seeking counseling due to a court order or criminal charges? ☐ Y ☐ N

Client Information

Last Name_____ First Name_____ Middle Initial_____

Birth Date_____ /_____ /_____ Social Security Number_____-_____-_____

Street Address_____ Apt #_____

City_____ State_____ Zip_____ Phone_____

Email_____

Gender: ☐ Male ☐ Female

Relationship status: ☐ Single ☐ Significant other ☐ Cohabitating ☐ Engaged ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Racial/Ethnic identity: ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Native American
☐ Pacific Islander ☐ White/Caucasian ☐ Other_____

Emergency Contact: Name_____ Contact number_____

Relationship to the client_____

Military: ☐ Active Duty ☐ National Guard/Reserves ☐ Prior Service ☐ Retired ☐ Dependent
☐ Medically Separated ☐ Service Connected Disability ☐ Combat Veteran
☐ Branch_____ Dates of Service_____

Employment: ☐ Full-Time ☐ Self-Employed ☐ Part-Time ☐ Homemaker
☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Employer_____

What type of work do you do?_____

Family:

Parents Mother Living (age) _____ Deceased (date) _____

Father Living (age) _____ Deceased (date) _____

Siblings How many?_____ I am the: ☐ Oldest ☐ In the Middle ☐ Youngest ☐ Only Child

Names and ages of your children_____

Names and ages of step-children_____

Who lives at home with you?_____

Have you or anyone in your family experienced domestic violence or abuse? ☐ Y ☐ N

If yes, please explain: _____

Are you currently experiencing domestic violence or abuse? ☐ Y ☐ N

Religion/Denominational preference_____ Church _____

Medical History of Client

Primary Physician_____ Date of last medical examination_____

List any physical illness or symptoms you are having at this time_____

List current medications (include dosages and physician prescribing)_____

_____

_____

_____

_____

Check all that you have experienced in the last month

☐ Thoughts of suicide	☐ Anxiety	☐ Rage
☐ Thoughts of death	☐ Excessive worry	☐ Anger
☐ Plans to harm self	☐ Panic Attacks	☐ Irritability
☐ Thoughts of harming others	☐ Chronic fear	☐ Relationship to significant other
☐ Plans to harming others	☐ Irrational fears	☐ Relationship to parents
☐ Self-injury	☐ Problems due to abuse/trauma	☐ Relationship to children
☐ Loss of meaning in life	☐ Stress	☐ Sexual problems
☐ Loss of hope	☐ Obsessions	☐ Sexual orientation
☐ Depression	☐ compulsions	☐ Gender identity issues
☐ Decreased pleasure	☐ Phobias	☐ Conflicts at work
☐ Lack of activities	☐ Feel like I'm losing control	☐ Problems in school
☐ Isolating/withdrawn	☐ Restlessness	☐ Loss of faith in God
☐ Decreased energy/fatigue	☐ Muscle tension	☐ Religious doubts
☐ Change in appetite	☐ Problems with sleep	☐ Substance use problems
☐ Significant weight change	☐ Problems with concentration	☐ Hallucinations
☐ Feelings of worthlessness	☐ Problems with memory	☐ Delusions
☐ Grief	☐ Avoid open spaces	☐ Easily distracted
☐ Loneliness	☐ Behavioral problems	☐ Other/Explain below
☐ Guilt feelings	☐ ADHD	

What else are you experiencing at this time?_____

Mental Health History

Have you experienced mental health problems before? ☐ Y ☐ N If yes, explain_____

_____

Do you have a family history of mental health problems? ☐ Y ☐ N

Have you ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

☐ Y ☐ N If yes, when and where?_____

Have you ever been hospitalized or received inpatient treatment for mental health issues? ☐ Y ☐ N If yes, when and where?_____

Self-Harm

Have you wished you were dead or wished you could go to sleep and not wake up? ☐ Y ☐ N

Have you had any actual thoughts of killing yourself? ☐ Y ☐ N Plan? ☐ Y ☐ N

Have you ever attempted suicide? ☐ Y ☐ N If yes, number of attempts_____

Have you ever lost someone you care about to suicide? ☐ Y ☐ N

If yes, who and when?_____

Substance Use History

Do you drink alcohol? ☐ Y ☐ N On average, how many drinks do you have?_____ per _____
quantity & type *day/week/month*

Do you use drugs (illegal drugs, recreational drugs, drugs not prescribed to you or used in excess of how they are prescribed)? ☐ Y ☐ N If yes, which ones?_____

How often?_____ per_____ IV drug use? ☐ Y ☐ N
quantity & drug *day/week/month*

Have you ever received outpatient treatment (counseling, therapy, psychiatrist, or medication) for a drug or alcohol problem? ☐ Y ☐ N If yes, when and where?_____

Completed successfully? ☐ Y ☐ N

Have you ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

☐ Y ☐ N If yes, when and where?_____

_____ Completed successfully? ☐ Y ☐ N

Are you coming in for Alcohol and/or Drug Addiction? ☐ Y ☐ N

What other information is it important for your therapist to know?

_____

_____

Acknowledgement

The information written on this form is accurate, to the best of my knowledge.

Signature of Client _____ Date _____

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Appointment Reminder Preference

Client Name: _____

New Hope Counseling Center utilizes a contracted service to provide automated reminders of your next appointment 24 – 48 hours in advance as a courtesy reminder. Please choose a reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

_____ _____
Signature of Client Date

_____ _____
Signature of New Hope Staff Date

No Shows and Cancellations

Client Name: _____

When you schedule an appointment with our staff, New Hope Counseling Center reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. If you fail to give 24-hour notice before cancelling your appointment or do not show for your appointment up to two times, your therapist has the right to refuse services or you may be asked to make your appointment two to three weeks from missed appointment date. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation.

Due to the counselors maintaining a set schedule:

- If you are 30 minutes late for 60-minute appointment, you will be able to be seen for 30 minutes.

By signing this agreement I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

_____ _____
Signature of Client Date

_____ _____
Signature of New Hope Staff Date

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Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction.

I am making an informed decision, free of any coercion, to engage in psychotherapeutic/counseling/clinical social work services. It is my right to terminate these services at any point.

_____ _____
Signature of Client Date

_____ _____
Signature of New Hope Staff Date