



This form will enable us to gain a quicker understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. If you are a couple, please fill out two forms, one for each person.

Date _____

Name _____ Age _____ Sex _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Date of birth _____

Marital Status (Circle one): Single Married (# of years _____) Divorced (How long? _____) Separated

Occupation _____ Total hours/week _____

Employer (or school) _____ Full-time Part-time

Address of employer _____

Primary Care Physician (PCP) _____

Address _____ Phone _____

Family member to notify in case of emergency _____

Emergency contact phone number _____

Who gave you my name? _____

May I have your permission to thank this person for your referral? Yes No

Would you like to receive information regarding upcoming events and groups offered by Paraclete? Yes No
If yes: (Email) _____

Do you expect to be involved in any legal action where your counselor's documentation or testimony will be required?

Please explain. _____

Concerns Check List

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Depression | <input type="checkbox"/> Education | <input type="checkbox"/> Eating difficulties |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Social relationships | <input type="checkbox"/> Problems with children | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Problem with parents | <input type="checkbox"/> Spiritual concerns | <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Trouble making decisions | <input type="checkbox"/> Unhappy most of the time | <input type="checkbox"/> Use of alcohol | <input type="checkbox"/> Use of other drugs |
| <input type="checkbox"/> Work | <input type="checkbox"/> Worry | <input type="checkbox"/> Thought of harming someone else | |
| <input type="checkbox"/> Cutting or burning self | <input type="checkbox"/> Other (Specify) _____ | | |

Suicidal/Homicidal Ideation

Have you ever attempted to commit suicide or homicide *in the past*? _____

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? _____

Recent Losses (Please circle all that apply)

Family Health Disruption in lifestyle Job Significant other Other _____

Psychiatric History (Please list any previous inpatient and outpatient counseling and/or addiction treatment experiences)

Place	Dates	Length of Time	Inpatient or Outpatient	Reason

Name of current psychiatrist _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep

Medical Information

Describe any current medical condition _____

Height _____ Weight _____

Please list the name of the medication, dosage, frequency, prescribing physician and the date started (or attach a list).

Medication/Supplement	Dosage	Frequency	Prescribing Physician	Start Date

Date of your last physical exam including blood test? _____

Have you ever had an abortion? _____

Do you have any allergies? _____, If so, list them _____

Please list any previous health problems, operations and medical hospitalizations:

Substance Abuse History

Describe your current usage or usage within the past year of the following:

	First Use	Last Use	Average Amount	Frequency of use
Alcohol				
Marijuana				
Caffeine				
Meth				
Cocaine				
Heroin				
Pain Medication				
Morphine				
Nicotine				
Pornography				
Gambling				
Other _____				

Have you experienced a *recent increase* in the use of alcohol and/or other substances? _____

Do you see your current usage as a problem? _____

Is there a history of alcohol and substance abuse in your family? _____, If so, who? _____

Nutrition

Have your eating habits changed recently? Yes No

Has your weight fluctuated more than 10lbs. +/- over the previous year? Yes No

Do you often eat out of depression, boredom, and anger? Yes No

Do you ever self-induce vomiting? Yes No

Do you ever binge eat or feel your eating is out of control? Yes No

Do you use laxatives, water pills, or diet medications? Yes No

How do you feel about eating with others in a group? _____

Legal History (Please circle all that apply)

Charges as a minor Charges presently Arrests Incarcerations Parole Convictions
 Probation Bankruptcy Civil suit DUI Other _____

Developmental History

List members of your family that you grew up with

What was your birth order? ____ of ____ children Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? _____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Support System

Who can you count on for support? _____

Who are you currently living with? _____

Financial Situation

Describe briefly your financial situation _____

Marital History (if applicable)

Previous marriage? Yes No If yes, date of divorce _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations)

Religious/Cultural Factors

What is your ethnic/cultural background? _____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? Yes No ACTIVE INACTIVE

If yes, please list where you attend. _____

Work History

Describe your current job/career _____

Would you enjoy doing this job on a long-term basis? _____

If you could have any job/career, what would you choose? _____

How do you deal with authority figures? _____

Describe your relationship with co-workers _____

Describe your job performance _____

Have you ever been fired? Yes No If yes, explain _____

How many jobs have you held within the previous five years? _____

Were you ever in the military? _____

Educational History

Highest level achieved _____ What type of grades did you make? _____

Are you currently in school? Yes No If yes, what level? _____

Family

Spouse's Name _____ Age _____ Birthdate _____

Children

Name	Age	Living with you (y/n)	Biological, Step, Adopted or Foster?	Custody

Would it be beneficial for any members of your family to be involved in your treatment? Yes No

If yes, explain _____

Is there anything else you feel that we need to know about you? Yes No

If yes, please explain _____

FINANCIAL INFORMATION SHEET

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees or co-pays are due at time of service. You may use cash, check, debit cards, Visa, MasterCard or Discover.

PART A

Total gross family income _____ # of dependents _____

Who is financially responsible for these fees? _____

Do you have insurance? _____

If your therapist is a contracted provider with your insurance company, we will file all claims. If the therapist is **not** a contracted provider, we will verify whether you have out-of-network benefits. If you do, we will file for you; and you will be responsible for all deductibles and co-pays. If you do not, no claims will be filed; and you will be responsible for all fees at the time of service.

ALL BLUE CROSS/BLUE SHIELD CLIENTS MUST FILE THEIR OWN CLAIMS. BLUE CROSS/ BLUE SHIELD WILL ONLY REIMBURSE THE INSURED NOT NON-NETWORK PROVIDERS.

PART B

Is your therapist a part of your managed care plan? ___Yes ___No ___I Don't Know

Primary Insurance Company _____

Address _____

Phone Number of Insurance Company _____

Policy # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Date of Birth _____

Insured's Employer _____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Signed this _____ day of _____, 20____; in the city of _____, situated in _____ county, state of Georgia.

Signed _____ Date _____

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