Confidential Confessions Counseling Services
2302 West Meadowview Road. Suite #108
Greensboro, NC 27407
Office: 336 -355-1811 Fax: 336-698-4122
Email: info@cccounsel.me

Intake Form

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as the therapy. Please print out this form and bring it to your first session.

Today's Date: ____/____/_____ SS #_____

Name: _____
(Last) (First) (MI)

Primary Insurance:_____ Policy#:_____

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Transgender Race:_____

Local Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

IF CLIENT IS A MINOR:

Parent/Guardians Name:_____ _____
(last) (First)
Parent/Guardians
Local Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home #: _____ Cell#:_____

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Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Do you have children? □No □Yes If yes, how many?: _____ Ages: _____

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care doctor:_____ _____
(Name) (Phone)
Primary Care doctor:_____ _____
(Name of practice) (Address)
Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

_____

Medications:_____

_____

Hours per night you normally sleep _____

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep

Do you exercise regularly? □ No □ Yes

If yes, how many times per week do you exercise? _____ For how long? _____

If yes, what do you do?_____

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes
Do you regularly use alcohol? □ No □ Yes

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If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you checked any box other than "never," which drugs do you use?

_____

Do you smoke cigarettes? □ No □ Yes

If yes, how many cigarettes per day?_____

Do you drink caffeinated drinks? □ No □ Yes

If yes, # of sodas per day_____ cups of coffee per day_____

PSYCHIATRIC INFORMATION:

What prompted you to seek therapy or an assessment at the current time(**please be specific**)?

1. _____
2. _____
3. _____

What are your overall goals for therapy?

1. _____
2. _____
3. _____

In the last year, have you experienced any significant life changes or stressors?

_____
_____
_____

Have you had previous psychotherapy? □No □Yes

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If yes, why?_____

If yes, when?_____

If yes, where?_____

Are you currently taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If Yes, please list names and doses_____

If No, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list names and dates:_____

Are you hopeful about your future? □Yes □No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, have you recently done anything to hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did you have these thoughts?_____

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No

Have you previously had homicidal thoughts? □Yes □No

If yes, when?_____

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Are you employed? □ No □ Yes

If yes, who is your current employer/position? _____

Please list any work-related stressors, if any: _____
Do you have financial concerns? □ No □ Yes

If yes, please explain: _____

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Are you currently in the military? □ No □ Yes Previously? □ No □ Yes
Highest level of education:_____
Do you have any legal concerns? □ No □ Yes
If yes, please explain:_____

FAMILY HISTORY:

Are your parents: □ still together □ divorced, when_____
□ remarried □ unmarried
□ deceased, if yes whom_____ age at death_____

Number of siblings:_____ Ages:_____

Do you have good family support? □ No □ Yes From whom?_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

EMERGENCY CONTACTS:

1. Name:_____ Phone:_____ Relationship to client _____

2. Name:_____ Phone:_____ Relationship to client _____

REFERRAL:

Who referred you to Confidential Confessions Counseling Services?
Name;_____ Phone:_____
If known, name of practice or Program_____
May I have your permission to contact this person for the referral? □ Yes Revised on1/5/17

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Client Authorization Form

Client Name: _____ DOB:_____

Date:_____ Acc/Medicaid ID#_____

AUTHORIZATION/RESPONSIBILTY ACKNOWLEDGEMENT

I acknowledge and understand that I am responsible for my mental health care services. I agree to pay for services as they are provided, unless covered by my allotted benefits in the insurance plan. If for any reason there is a balance left owning on my account, I agree to pay promptly upon receipt.

I authorize the release of my outpatient information necessary to process insurance claims. If assignment of benefits is accepted, I authorized payment to Confidential Confessions Counseling Services, PLLC.

Client Initials_____

CLIENT PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been offered Confidential Confessions Counseling Services, PLLC Notice of Privacy Practices containing a more details of the use and disclosure of my mental health information.

Client Initials_____

DESIGNATED PARTY RELEASE AURHTORIZATION

I authorize Confidential Confessions Counseling Service, to disclosure my outpatient information care to the following person or entity:

Name of person/entity: _____ Relationship to client: _____

Address: _____ Purpose: _____

I authorize Confidential Confessions Counseling Services to communicate my personal health information by leaving a detailed message/fax/email or by automated call/text (e.g. appointment reminders via the following methods: **Please note that email may not be secured**

☐Home answering machine (phone#_____) ☐Voicemail at work (phone #_____)

☐Cell phone voice mail (phone#_____) ☐ Faxed Medical information (Fax#_____)

☐ Email medical information (email address:_____)

Client Initials_____

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PLEASE COMPLETE SYMPTOMS SCALE

Are you **currently** experiencing:			Rating Scale 1-10(10 worst) *Only rate the areas to which you say "yes"*
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Hallucinations	yes	no	_____
Paranoia	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Body Image Problems	yes	no	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____
Self Mutilation	yes	no	_____
Sexual Abuse	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

Have you experienced in the **past**:			Rating Scale 1-10 (10 =worst) *Only rate the areas to which you said "yes"*
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
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Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____