Adult Intake Form

Name _____ Age _____ Sex _____ Date of Birth ____/ ___ / ___

Street Address _____ Phone (h) _____

City, State, Zip _____ Phone (w) _____

Email address _____ Phone (cell) _____

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

Current Marital status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

Date of Current Marriage/Separation: _____ Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____

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

Please list specific 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
☐ INDIVIDUAL	1-on-1 counseling	1 intake form
☐ FAMILY	2 or more family members	1 intake form per person over 18 yrs. old
☐ RELATIONSHIP	Couples who are dating	1 intake form per person (total of 2 forms)
☐ PREMARITAL	Couples engaged or considering it	1 intake form per person (total of 2 forms)
☐ MARITAL	Couples needing marital guidance	1 intake form per person (total of 2 forms)

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

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 problems currently for

- ☐ 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
- ☐ Feeling manipulated or controlled by others
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationships
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Concerns about physical health
- ☐ Blackouts or temporary of loss of memory
- ☐ Insomnia (no sleep) or Hypersomnia (sleep all the time)
- ☐ Loss of appetitefincreased 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 that people are "out to get you' or that you're being watched
- ☐ Feeling trapped in rooms/buildings
- ☐ Hearing voices

MEDICAL/HEALTH INFORMATION

How would you rate your current physical health? ❑ Excellent ❑ 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 _____

Have you ever been hospitalized for psychiatric purposes? ❑ Yes ❑ No

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

_____

Permission to contact previous counselor: ❑ Ye ❑ No List names of any previous counselors/ therapists, including dates and contact number:

_____

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

What do you hope to gain from counseling? _____

OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation_____ Employer _____ Present annual income: $ _____

If Currently a Student: Field of Study _____ Part-Time ❑ Full-time❑

Institution, University or College _____

RELIGIOUS BACKGROUND *(optional)*

Do you believe in God? ❑ Yes ❑ No Religious preference: _____

What church do you currently attend?_____ Are you a member of Crossroads? ❑ Yes ❑No

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

CONSENT OF RELEASE OF INFORMATION

In the event that a Crossroads Counselor is not available to address the needs of the client, due to scheduling or otherwise, Crossroads Counseling is authorized to release all intake information to a referred counselor. The consent for release of information avoids any delays in beginning counseling and insures that the client receives appropriate care.

Signed _____ Date _____

Crossroads Community Church

CONFIDENTIALITY STATEMENT

Confidentiality is our promise to you. We will keep everything you share in counseling sessions or in care groups or workshops completely private and in confidence. Whatever you do or say during a session, group, or workshop will not be shared with anyone without your written consent.

However, there are certain exceptions to this policy of which you need to be aware. The group or workshop leader, the counselor, the pastoral staff, or the Director of Counseling may disclose information in the following situations:

- If you have been referred by the court or an agency of the court, the group or workshop leader, the counselor, the pastoral staff, or the Director of Counseling may be required to furnish information to such agencies or representatives of the court.
- If you are involved in certain kinds of litigation and inform the court of the services you have received, you may be waiving your right to have your records remain confidential. (This would be clarified by your attorney).
- If you threaten to harm yourself or others, confidentiality may be breached in order to ensure protection for the endangered party or parties.
- If there is reason to believe you are currently involved in child abuse or neglect, the law requires that the appropriate agency be informed.
- If you are a minor, your parents or guardians must be informed of your progress upon request. However, specific details of your conversation will not be revealed without your prior notifications.

COUNSELING, GROUP, OR WORKSHOP AGREEMENT:

I have read information outlined above. While a Biblical framework is openly advocated in sessions, groups, or workshop, I understand that my choices about my own thoughts, beliefs, feelings and behaviors will be respected.

LIMITS OF CONFIDENTIALITY:

I have read and understand the above statements regarding breaching of confidentiality. Please sign and return.

Name: _____ Date: _____
Print

Signed: _____ Date: _____
Signature

HIPAA PRIVACY STATEMENT

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures for Treatment and Health Care Operations

I may use or disclose your Protected Health Information (PHI) for treatment purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
  Treatment" is when I provide, coordinate or mange your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
  Disclosure applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purpose outside of treatment when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have made about our conversation during a private, group, joint or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization.

Uses and disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the ACS.

Adult and Domestic Abuse: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat. I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Diaconate: If you are receiving funding for counseling sessions, I will be required to file periodic reports with your deacons/pastors which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

For Members of Redeemer Presbyterian Church Only: If you persistently refuse to renounce a particular sin, the assistance of church leaders will be necessary in accords with your vows as a member of Redeemer and in accords with Matthew 18:15-20.

HIPAA CONSENT FORM

This certifies that I have received from my counselor at the Crossroads Counseling Center a copy of the notice of policies and practices to protect the privacy of my health information.

Signature of Client	Date
Signature of Client	Date
Signature of Client	Date
Signature of Parent or Legal Guardian (if Client is under 18)	Relationship to Patient