Newport Counseling Center, LLC

Intake face sheet

Client's Name: ______________________________ Referred by:___________________________________
Address: __________________________________City:__________________________Zip:_______________
Phone: (H)____________________(W)________________(cell)____________________________________
SS#:_________________Age:_____ Birth Date:____________ Email: ___________________________
Ocupation: _____________________________________ Employer/School:___________________________
Insurance Company:_________________________ Cardholder name:_________________________________
Insurance ID#_____________________________Group#______________________________________
Name and phone number of emergency contact person (not living in your house).
____

If client is UNDER 18 years of age, please complete this section:

Mother:______________________________ Phone:(H)_____________________(C)____________________
Address:____ (W #):______________________
Birth Date: _______________________ Email: ____
Employer/Occupation:________________________ Insurance ID#______________________
Insurance Carrier:____________________________Group#: ________________________________

Father:_______________________________Phone:(H)_______________(W)________________________
Address:____Cell:______________________________
Birth Date: ______________________ Email: ____
Employer/Occupation:________________________Insurance ID#______________________________
Insurance Carrier:____________________________Group#: _______________________________________

I consent to release any medical or other information necessary to process this claim. In addition, this signature authorizes payment of medical benefits to the provider for services rendered. I understand that if my insurance does not pay the claim, I am responsible for payment of all charges for services rendered. I also understand that I am responsible for any co-pays at the time of service at the specialist rate. It is the responsibility of the client to know what their insurance benefits are.

Signature: ____Date:______________________
(Parent/Guardian must sign if client is under 18 years old)

Cheryl Woodcock, LCSW ❖ Melissa Hixson, LCSW ❖ Lori Amey, LCSW
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Newport Counseling Center
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Consent for Treatment
Acknowledgment of Policies & Rights

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for treatment for the minor or person under my legal guardianship mentioned here: ________________________________at NEWPORT COUNSELING CENTER LLC, hereby referred as NCC. The rights, policies, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. NCC encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Privacy of Information Policy (see Client Policy Packet)
I certify that I have received a copy of the Privacy of Information Policy. __________(initial)

Conditions for Treatment Termination (see Client Policy Packet)
I certify that I have received a copy of the Conditions for Treatment Termination Policy. ________(initial)

By signing below, I give my consent to treatment and agree to abide by the policies and agreements with Newport Counseling Center, LLC.

____ Date: __________________
Client Signature (14 yrs and older)

-OR-

____ Date: _________________
Signature of Parent/Legal Guardian

____ _________________
Witness Date

ADULT INFORMATION FORM

(revised 7/2018)

Name: ______________________________ Date of 1st Appointment: ______________________

Date of Birth: ____________________ Age: ________ Gender: Male ______ Female ______

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address: ______________________________ Physician's Phone: ____________________

Date of last medical evaluation: ________________ Date of next appointment: ____________________

Please list any medical conditions below:

____

____

____

____

Please list medications on separate medication log attached

Have you ever been hospitalized for medical or psychiatric reasons? (**Circle one**) YES NO

If yes: Hospital Mo/Yr Reason

____________________ ________ ______________________________

____________________ ________ ______________________________

____________________ ________ ______________________________

Have you ever used recreational drugs? (**Circle One**) YES NO

If yes: Type of Drug How much How often

____________________ ________ ______________________________

____________________ ________ ______________________________

____________________ ________ ______________________________

____________________ ________ ______________________________

If in recovery, when and what did you last use? ____

Do you drink alcohol? (**Circle One**) YES NO

If no, did you drink previously? (**Circle one**) YES NO

If yes: Type of Alcohol (Liquor, Beer, Wine) How much How often

____________________ ________ ______________________________

____________________ ________ ______________________________

If in recovery, when and what did you last drink? ____

Do you smoke cigarettes? (**Circle One**) YES NO

Do you use other forms of tobacco? (**Circle One**) YES NO **If yes,** what kind? ____________________

Allergies: ____

Adverse reactions to medications: ____

Any withdrawal/DT/Seizure history: ____

Past and present treatment for the above;

____

____

____

MEDICATION LOG

Name of medication	Amount prescribed x taken per day	Who prescribed it?	Date of increase in dose/frequency

Name: ______________________________

Date: _____________________________

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: ____

____

____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: ____

____

____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic, or behavior problems as a child or while in school? (**Circle One**) YES NO

If yes, please explain: ____

What was the last year of school you completed? ____________

If you did not complete high school, please explain:

____

How would you describe your current support network? (friends, relatives, etc.): ____

____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

____

List first names and ages of brothers & sisters:

Name	Age	Relationship (natural, step, half, etc.)
______________________	_______	______________________
______________________	_______	______________________
______________________	_______	______________________
______________________	_______	______________________

Describe any family problems which occurred **while growing up** relating to:

Alcohol/drug abuse: ____

____

____

Sexual/physical/emotional abuse: ____

____

____

Name: ________________________
Date: _________________________

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? ________________

If living w/someone, how long? _______________________

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
______________________________	_____	________________	______________________________
______________________________	_____	________________	______________________________
______________________________	_____	________________	______________________________
______________________________	_____	________________	______________________________

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful

____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had: ____

____

Please list any past or present mental health treatment:

____

____

____

What activities or hobbies do you participate in? ____

____

Do you participate in regular exercise? (**Circle One**) YES NO

If yes, describe: ____

Describe your current working environment: ____

____

Have you had any change in sleeping habits? (**Circle One**) YES NO

Describe any **changes:** ____

____

Have you had any change in eating habits? (**Circle One**) YES NO

Describe any **changes:** ____

____

Are you considering suicide in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description: ____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: ____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: ____

Are you having any **homicidal thoughts** in regard to your **current** problem? (**Circle On**e) YES NO

If yes, please explain: ____

Have you ever **considered homicide** in the **past**? (**Circle One**) YES NO

If yes, please explain: ____

Name: ______________________

Date: ______________________

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social, or occupational functioning (Examples: isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): ____

____

____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear a voice even though no person nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior.

Please explain: ____

____

____

Is there any **other information** regarding you or your family that you would like to share with your Therapist that is **not covered on this form**? You may also use this space to complete earlier responses.

____

____

____

____

____

Please list your therapy goals:

____

____

____

____

____

Are there any cultural preferences you would like Newport Counseling Center to be aware of?

____

____

THANK YOU!