Client Information

Date: _____Referred by_____ May we thank them for the referral? Yes ___ No ___

Identification

Name: _____ _____ Date of Birth: _____ Age: _____
First Last

Marital status: _____ Male ___ Female ___ If client is a minor, resides with Father ___ Mother ___ Both ___

Address: _____ _____ _____
Number Street Apt

City: _____ State: _____ Zip: _____

Contact Information

OK to leave messages?

Home Phone: _____ Yes ___ No ___

Work Phone: _____ Yes ___ No ___

Cell Phone: _____ Yes ___ No ___

email: _____ Yes ___ No ___

Responsible Party

Person responsible for payment (if different from above)

Name: _____ _____ Relationship: _____
First Last

Address: _____ _____ _____
Number Street Apt

City: _____ State: _____ Zip: _____

Marital History

Spouse's Name	Years Married	Relational Issues?

Children

Name	Age	Gender	School & Grade	Behavioral or Adjustment Problems?	Quality of Relationship

Client Information

Emergency Contact

Name_____ Relationship _____Address:_____

Phone:_____

*Note: This will only be used in the event of a medical or psychological emergency in our offices.

Medical Care

Please list all Physicians you see regularly

_____ _____ _____

Name Phone Reason

_____ _____ _____

Name Phone Reason

_____ _____ _____

Name Phone Reason

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Serious accidents, illnesses, or hospitalizations (please list)

_____ _____

Incident Year

_____ _____

Incident Year

_____ _____

Incident Year

Health Issues

Appetite: Good ___ Average ____ Poor ___ Sleep: Good ___ Average ___ Poor ___

Alcohol: ____ drinks per _____ Tobacco: Yes ___ No ___ Recreational Drugs: Yes ___ No ___

High Blood Pressure: Yes ___ No ___ Thyroid problems: Yes ___ No ___ Diabetes: Yes ___ No ___

Any Current Medical Problems? (please list) _____

_____

Employment

Current Occupation:_____

How long? _____ Any issues with work? _____

Previous Occupation(s):_____

How long? _____ Any issues with work? _____

Client Information

Family of Origin

Relative	Name	Age	Illness?	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						
Brother(s)						
Sister(s)						

Reasons for Seeking Counseling

_____

_____

Attempted Solutions

How have you attempted to solve the problems that have brought you to therapy?

_____

_____

Previous Counseling Experience

Therapist Name	Clinic Name	When/How Long?	City, State	Reason(s)

What was helpful about these experiences?

_____

_____

What was unhelpful?

_____

_____

Client Information

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. *Please rate every item*.

0 1 2 3 4 5 6 7 8 9 10

No Concern — Moderate Concern — Extreme Concern

Score	Issue	Score	Issue
	Anger		Mood Swings
	Abuse Victim		Problems with Children
	Aggression/Violence		Problems with Parents
	Anxiety		Problems with Social Relationship
	Attention/Concentration		Religious and/or Spiritual Concern
	Compulsions		Self-Harming Behavior
	Confusion		Sexual Concern
	Depression		Thoughts of Suicide
	Divorce/Separation		Trouble Making Decisions
	Education		Unhappy Most of the Time
	Eating/Appetite Problems		Unwanted/Intrusive Thoughts
	Fears of Specific Objects or Events		Use of Alcohol
	Grieving/Mourning		Use of Alcohol by Family Member
	Impulsiveness		Use of Other Drugs
	Financial Problems		Use of Drugs by Family Member
	Legal Problems		Work
	Marital Problems		Worry
	Medical/Physical Problems		Hallucinations
	Sleeping Problems		Smoking
	Thyroid Problems		Other (specify)_____

Client Information

PLEASE NOTE: If you feel suicidal after office hours or you are unable to reach your therapist at any time please call the suicide hotline at 1-800-227-8922 or your psychiatrist/physician emergency phone number. The counseling center staff does not operate as a crisis center and we do not carry pagers. We are only available during the hours your therapist is in the office. The assessment staff at Peachford Hospital is also available at 770-455-3200.

Client Signature: _____

Disclosure

Please review and discuss any questions you may have with your therapist.

The following information pertains to the treatment and financial policies of North Atlanta Counseling Associates, Inc. Please note that North Atlanta Counseling Associates, Inc. also does business as North Atlanta Center for Christian Counseling, Cumming Christian Counseling, Faithful and True Atlanta, Story Restoration, and Northwest Counseling Services. These names represent the same group. Please sign and date this form at the bottom of the page. We will be happy to provide a copy for your records.

I. PSYCHOLOGICAL SERVICES Psychotherapy is not easily described in general statements. It may vary depending on the personality of the client and the therapist and the specific problems being addressed. There are a number of different approaches that can be utilized to work on the problems you hope to address. It is different from medical treatment in that it requires a very active effort and commitment on your part. In order to be successful you will need to work both in session and at home. There are both benefits and risks to psychotherapy. The risks include experiencing uncomfortable levels of anxiety, sadness, anger, frustration, and a variety of other emotions. Psychotherapy has also proven to have many benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems. There are no guarantees about what will happen. Please discuss any reactions and emotions experienced during psychotherapy with your therapist. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a commitment of time, money, and energy. If there are any questions about procedures please discuss them with your therapist when the issues arise. If your doubts persist, we will be happy to help you with a referral to another mental health professional.

II. PROFESSIONAL RECORDS Both law and professional standards require the keeping of appropriate treatment records. Because these are professional records they can be misinterpreted and/or can be very upsetting. If you wish to see your records please submit a request to your therapist and the center director. It is strongly recommended that these records be reviewed with your therapist to discuss their content. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.

III. MINORS If you are under eighteen (18) years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before any information is disclosed I will discuss the matter with you and attempt to resolve any objections or concerns you might have.

Name: _____

Disclosure

IV. CONFIDENTIALITY In general, the confidentiality of all communications between a client and a counselor or therapist is protected by law, and I can only release information about our work to others with your written permissions. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it. There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must (may be) required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am (may be) required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. These are rare situations that have seldom arisen in my counseling practice. Should such a situation occur, I would make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together. While this summary of exceptions to confidentiality can be helpful in identifying potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions of summaries of the applicable state laws governing these issues. In order to insure the highest possible standard of care, the staff of North Atlanta Counseling Associates, reserves the right to consult with staff members and appropriate professionals regarding your treatment. You will not be identified, and all consultation will be held in strict professional confidence. Your signature indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature Date