

Adult Intake Form

Date of Intake: ___/___/___

A. Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender: Male Female Not Listed: _____ | Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact #: _____ Home/Cell or Work Email: _____

Preferred method of contact: Home/Cell | Work | Email | Ok to leave message/text? Yes
 No

(Please be advised that call/emails will be discreet)

Race/Ethnicity: African American/Black American Indian or Alaskan Native Asian

Hispanic Native Hawaiian White Multi-Racial Other _____

Emergency Contact: By listing the contact information below and **initialing here** _____, you are giving Sound Living Counseling Center (SLCC) permission to contact this person in the event of a physical or mental health emergency including but not limited to a life-threatening situation, a client's death/incapacitation, or imminent risk of harm to self/others should such contact be deemed beneficial by the SLCC staff member(s):

Contact Name: _____ Phone #: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

B. Family/ Social History:

Marital Status: Married Single Widowed Divorced Separated In a Relationship

Name of Partner: _____ Date of Birth: _____ Age: _____

How many years together: _____

How would you describe this relationship?

Children

Name	Age	Gender	Grade	From previous relationship?	Live with you?	Is this a step-child?	Mental Health diagnosis?

Extended Family

	Current Age (or age at death)	Medical Illness Diagnosis (or cause of death)	Mental Health Diagnosis
Father			
Mother			
Step-parent			
Step-parent			
Brother			
Brother			
Sister			
Sister			

C. Employment/Military Duty:

What is your current employment status? Employed Unemployed Retired Disabled

If employed, where? _____

Work Phone: _____ Address: _____

Ok to call or leave message? Yes No (Please be advised that call/emails will be discreet)

Military Service: Yes No If yes: Eventful Uneventful Traumatic Abroad

D. Referral Source

Employer Friend Hospital Physician/Psychiatrist Counselor Other _____

Name/Business/Organization: _____ Phone #: _____

Address if known: _____

Permission to send "thank you" to referral? Yes No

Employer require notice of attendance? Yes No

(SLCC would love to thank each of our referral sources if the client is comfortable with us reaching out)

E. Reason for seeking assistance:

Chief Complaint: _____

History of Present Illness: -Diagnoses, by whom and when?

Have you seen another Behavioral health clinician in the past 6 months? Yes No

Past or current Psychiatric/ Psychological Treatment, by whom and when?

Past Major Medical/ Surgical History, by whom and when?

F. Medical

PCP Name: _____ Phone#: _____

Current Medication List

Medication:	Dose:	How Long on This Med?	Frequency:	Prescriber:	Reason:

Describe any medication changes within the last 6 months:

Please describe your physical health over the past 6 months:

Do you exercise? Yes No If so, how and how often?

Suspicious Drugs (Allergies):

Drugs generic name ± additives indications:	Daily dose / Route of application / duration of therapy:	Interval between dose and interaction	Previous therapy with this drug:
1.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____
2.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____
3.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____
4.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____
5.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____
6.	.....mg/d.....;.....d		<input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> yes, Symptoms _____

Drug / Alcohol Assessment

Which substances are currently used:	Method of use: Oral, Inhalation, Intranasal, Injection.	Amount of Use	Frequency of Use: (Times/Month)	Time Period of Use	If not currently using, have you used it in the past?
Alcohol					
Caffeine					
Nicotine					
Opiates					
Marijuana					
Meth					
Stimulants					
Hallucinogens					
Other					

Suicidal/ Homicidal Assessment:

Do you have suicide or homicidal ideation: Yes No

Previous Attempt(s) When: _____

1.) In the past month, have you wished you were dead or wished you could sleep and not wake up?

Yes No

2.) Have you had thoughts of actually killing yourself or hurting others?

Yes No

3.) Can the thoughts be managed?

Yes No

4.) Is safety plan needed or Crisis Response phone number needed?

Yes No

5.) High Risk Behaviors?

None Cutting Anorexia/Bulimia Head Banging Self-Injurious Behaviors

Describe any traumatic experiences:

Abuse Assessment

In the past year, have you been hit, kicked, or physically hurt by someone other than an intimate partner: Yes No

Have you ever been forced to have sexual contact that made you feel uncomfortable: Yes
 No

Have you ever been in a Domestic Violence relationship: Yes No

If yes, are you currently in this relationship: Yes No

If yes, do you need help creating a safety plan: Yes No

G: Coping Skills and Needs Assessment

Describe how you handle stressful situations:

What are your needs?

What hobbies or recreational activities do you enjoy?

What are your personal goals?

What are your strengths?

What are your challenges?

Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work effectively together, we ask that you carefully read the information below. The services provided are rendered regardless of race, color, birthplace, language, gender, age, religion or disability. If you have any questions, your counselor will be happy to discuss them with you.

Introduction:

Sound Living Counseling Center is in place to serve the needs of people in the community and the church. The mission is to make a difference in families and individuals utilizing family systems theory, solution focused therapies and faith-based practices that encourage hope and motivate success. This office provided hope, help and healing to men, women, adolescents, couples, and families.

If a client appears to need additional services such as medication management, evaluation of child for custody issues or the possible occurrence or extent of abuse, we will provide referrals to appropriate professionals within the patient's community. It is important to note that we cannot provide forensic evaluations as part of this facility.

Counseling Fees:

Price	Description	Duration
\$110	Intake – Psychiatric diagnostic interview examination	1 – 2 unit/hours
\$90	Individual Psychotherapy	1 to 2 unit/hours
\$100	Individual Psychotherapy	60 minutes (1unit/hour)
\$100	Family Psychotherapy, without the patient present	1 to 2 unit/hours
\$100	Family Psychotherapy, with the patient present	1 to 2 unit/hours
\$50	Group psychotherapy	1 hour
\$0 - \$45	Sliding Fee scale available for those without insurance	1 to 2 unit/hour

We ask that your account be kept current and that your payment be made by check or cash prior to each session. Should the agreed upon fee not be paid for three sessions no further sessions will be scheduled until the balance is paid, unless you have discussed this issue and worked out an agreement with your counselor.

Please make checks payable to: **Sound Living Counseling Center**

Sound Living Counseling Center can also apply donations to the fee or fees for services. This may include, but not be limited to, donations to finance all or part of the client's cost for services; or payments made to the agency for a client's participation in an employment or rehabilitation program to finance the cost of services provided.

Hours of Operation

Sound Living Counseling Center is operated 9am-5pm Monday through Thursday, other hours may be available by appointment. Please call 423-682-7203 for scheduling.

Insurance:

We accept the following insurance cards: Access one EAP, Aetna, Alliant, Amerigroup, Blue Cross Blue Shield, Blue Care, Cigna, ComPsych, Cover Tennessee, Humana, Life Synch, Magellan, Magellan EAP, Optimum, Tricare, United Healthcare and Value Options. If you need assistance and your insurance company is not listed please let us know as we are willing to contract with other insurance companies as needed. . Client is responsible for deductibles or copays not covered by client insurance.

Confidentiality Policy

Your privacy is important to us, and we believe that counseling is most effective when clients feel comfortable speaking openly with their counselor. We hope this information will clarify our privacy policies.

In the usual course of events, you have the right to keep your counseling here completely private. This means that, without your written permission, no information about your contact with Sound Living Counseling Center is available to anyone outside of this facility, including parents, family members, friends, or outside agencies. Please ask us if you have any questions about this, as we want to be sure you are comfortable with our practices.

There are certain exceptions to confidentiality, noted below, with which you should be aware before you enter into any counseling relationship. Please read carefully through these exceptions, and be sure to ask your counselor if you have any questions.

Exceptions to Confidentiality:

- If appropriate, your counselor may consult with your treating physician or other healthcare providers to coordinate your care or use your case for training purposes. If we consult a provider you will be asked to sign a release of information (ROI).
- If you pose a threat of harm to yourself, or to another person, we will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening. This may include communicating with your emergency contact.
- In the event of a psychiatric hospitalization we will consult a facility and you will be asked to sign a release of information (ROI).
- If you report information indicating that a child, disabled, or elderly person is suffering from abuse or neglect we are mandated state reporters.
- A court order, issued by a judge, could require us to release information contained in your records. For your protection, we prefer not to attend court and if required fees may apply.
- In the event you approve, an intern may be able to shadow for educational purposes. This student will also be held accountable for the confidentiality of the client, and will only consult with the therapist at hand.

- Client cases may be used in training counselors and interns and or students. If used for training purposes, no identifying information will be disclosed.

Cancelation of appointments:

If you must cancel your appointment, please call 423-682-7203 and leave a message on your counselor's voicemail or text counselor directly at least 24 hours in advance of your scheduled appointment. Your cooperation in this regard will be greatly appreciated.

Telephone calls:

Should you need to contact your counselor, you may leave a message our voicemail or contact via your counselor's cell phone. Our voicemail system will receive your message 7 days a week, 24 hours a day. Your call will be returned as soon as possible during week days.

Emergency procedures:

Since the counseling office is not staffed 24 hours per day, the counselors are not available to handle after hours emergencies. If you have an emergency, you will need to contact either a hospital emergency room or call 911 depending on the situation. Hamilton county residents may also call the *Mobile Crisis* number at 423-634-8995.

Additional Important Phone Numbers

Chattanooga, TN Police	911 or (423) 698-2525
Sound Living Counseling Center	(423) 682-7203
After-Hours Suicide Prevention Hotline	1-800-273-8255
Sound Living Counseling Supervisor	(423) 505-5475
Sexual Assault Crisis Center	(423) 755-2700
Domestic Violence and Crisis	(423) 755-2700
Behavioral Health Crisis Hotline	1-800-704-2651

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" handouts and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may end my services with my therapist at any time, and the only thing I will be responsible for is paying for the services I have already received. I understand that by ending this service, if it was ordered by the court or my employer, my therapist will follow-up as appropriate to update the referring party.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive has not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of Client or Person Acting for Client

Date

Printed name

Relationship to client (if necessary)