CARE AND COUNSELING CENTER *of Georgia*

OFFERING HEALING, WHOLENESS AND HOPE TO THOSE IN NEED
AND EDUCATING OTHERS FOR THIS SERVICE
www.cccgeorgia.org

Office Use Only
Client # _____
Ins. Dx: _____
Need Monthly Statement?
☐ Yes ☐ No
Therapist: _____
Therapist # _____
Center # _____
EAP ☐ Yes ☐ No
☐ Individual ☐ Family

CLIENT INTAKE INFORMATION FORM

Today's Date: _____

GENERAL INFORMATION – ***Please print***

Name: Last_____ First: _____ MI: _____

Mailing Address: _____ City: _____ State: ___ Zip: _____

Responsible Party (if different than above)

Name: Last_____ First: _____ MI: _____

Mailing Address: _____ City: _____ State: ___ Zip: _____

	Preferred	*leave msg?*	
Home Phone _____	☐	☐ Y ☐ N	Email Address: _____
Work Phone _____	☐	☐ Y ☐ N	*Would you like to join our email list for monthly newsletters and upcoming workshops and groups?* ☐ *Yes* ☐ *No*
Cell Phone _____	☐	☐ Y ☐ N	*(We respect your email privacy. We will not share, transfer, sell or rent your information.)*

DOB: _____/_____/_____ ☐ Male ☐ Female SSN: _____-_____-_____

Place of Employment: _____ Job Title: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Racial/ethnic identity: ☐ American Indian or Alaska Native ☐ Asian or Asian Indian ☐ Black or African-American
☐ Hispanic or Latino ☐ Middle Eastern ☐ Pacific Islander or Native Hawaiian ☐ White

Marital Status: ☐ Single ☐ Engaged ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner's Name: _____ # of years together: _____

Religious/Denominational Preference: _____

Referred by: _____ May we thank the person? ___ Yes ____No

INSURANCE INFORMATION (***if applicable***)

Policyholder's Name: _____ Policyholder's Employer: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Policyholder's SSN: _____-_____-_____ Policyholder's DOB: ___/___/___ Relationship to Client: _____

Primary Insurance Carrier: _____ (Behavioral Health) Phone #: _____

City:_____ State:___ Zip: _____ Member #: _____ Group #: _____

Secondary Insurance Carrier: _____ (Behavioral Health) Phone #:_____

City:_____ State:___ Zip: _____ Member #:_____ Group #: _____

COUNSELING CONCERNS

Why are you seeking help now?

_____

_____

_____

What would you like to see happen as a result of counseling or psychotherapy?

_____

_____

_____

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name: _____ Physician's Phone: _____
Date of last physical: _____
List physical illnesses or symptoms ☐ Check if none

_____

_____

_____

Current Medication	Dosage	Frequency	Prescribing MD

Psychiatrist's Name: _____ Psychiatrist's Phone: _____

Have you ever had counseling or psychotherapy in the past? ☐ Yes ☐ No

If yes, when? _____ With whom? _____

Have you been seen at CCCG in the past 3 years? ☐ Yes ☐ No

If yes, when? _____ With whom? _____

Have you or any other family member received help for drug or alcohol dependency? ☐ Yes ☐ No

If yes, when? _____ Where? _____

Check which of the following you use, and note the amount and frequency of each:

☐ Caffeine: _____
☐ Coffee ☐ Sodas ☐ Other drinks ☐ Pills

☐ Tobacco: _____

☐ Alcohol: _____

☐ Marijuana: _____

☐ Cocaine, Crack: _____

☐ LSD: _____

☐ Inhalents: _____

☐ Other: _____

Have you been concerned or ever felt guilty about your use of drugs/alcohol? ☐ Yes ☐ No

Has anyone ever expressed concern about your use of drugs/alcohol? ☐ Yes ☐ No If yes, who? _____

Have you ever had a DUI? ☐ Yes ☐ No If yes, how many?_____ When? _____

Have you ever felt the need to cut down on your use of drugs/alcohol? ☐ Yes ☐ No

Have you or others ever felt annoyed by criticism of your use of drugs/alcohol? ☐ Yes ☐ No

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope with withdrawal symptoms? ☐ Yes ☐ No

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Checklist of Concerns

Please check any relevant concerns.

THOUGHTS/FEELINGS/MOOD

- ☐ Anger/frustration/hostility
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Confusion
- ☐ Depression
- ☐ Disliking others
- ☐ Emptiness
- ☐ Euphoria
- ☐ Excessive worry
- ☐ Failure
- ☐ Fatigue
- ☐ Fear
- ☐ Grieving (death, loss, divorce, etc)
- ☐ Guilt
- ☐ Hearing things other people don't
- ☐ Homicidal thoughts
- ☐ Intrusive thoughts
- ☐ Judgment problems
- ☐ Memory difficulties
- ☐ Negative thoughts
- ☐ Obsessive thoughts
- ☐ Oversensitivity to criticism
- ☐ Oversensitivity to rejection
- ☐ Panic attacks
- ☐ Perfectionism
- ☐ Sadness
- ☐ Seeing things other people don't
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Shyness
- ☐ Spiritual, religious, or moral issues
- ☐ Stress
- ☐ Sudden mood changes
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Thoughts of hurting self or others

BEHAVIOR

- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Argumentative
- ☐ Avoidant
- ☐ Compulsive behavior/rituals
- ☐ Controlling
- ☐ Decreased/lack of sexual interest
- ☐ Dependency
- ☐ Destruction of property
- ☐ Drug use – prescription, over-the-counter, street
- ☐ Eating problems
- ☐ Financial problems, debt
- ☐ Gambling
- ☐ Hyperactivity
- ☐ Internet problems
- ☐ Irresponsibility
- ☐ Isolation
- ☐ Legal problems
- ☐ Letting others take advantage of you
- ☐ Lying
- ☐ Not able to relax
- ☐ Pornography
- ☐ Preoccupation with sex
- ☐ Procrastination
- ☐ Purging
- ☐ Self destruction/sabotaging
- ☐ Self-neglect
- ☐ Sexual dysfunction
- ☐ Smoking
- ☐ Stealing
- ☐ Threats
- ☐ Weight, gain/loss
- ☐ Withdrawal from others
- ☐ Loss of interest on what I used to like
- ☐ Sleep difficulty
- ☐ Loss of appetite
- ☐ Overeating

FAMILY & RELATIONSHIPS

- ☐ Affair
- ☐ Childhood issues (your childhood)
- ☐ Divorce
- ☐ Friendships
- ☐ Housework/chores
- ☐ Interpersonal conflicts
- ☐ Parenting
- ☐ Problems with child(ren)
- ☐ Problems with parents
- ☐ Problems with spouse/partner
- ☐ Separation

ABUSE

- ☐ Abuse of alcohol
- ☐ Abuse of drugs
- ☐ Emotional abuse by another
- ☐ Emotional abuse of another
- ☐ Financial abuse
- ☐ Neglect
- ☐ Physical abuse by another
- ☐ Physical abuse of another
- ☐ Sexual abuse by another
- ☐ Sexual abuse of another
- ☐ Verbal abuse

WORK & SCHOOL

- ☐ Absenteeism
- ☐ Career concerns, goals, choices
- ☐ Difficulty with coworkers
- ☐ Difficulty with supervisor
- ☐ Performance
- ☐ Tardiness
- ☐ Procrastination
- ☐ School problems

OTHER CONCERNS

- ☐ _____

_____

- ☐ I have no problems or concerns bringing me here.

Revised 1/2013

(The information requested in this form will be kept confidential.)