Forward Movement Counseling Center
8105 Rasor Blvd Ste 250
Plano, Texas 75024 **469-854-9867**

Adult Intake Form

Today's Date: _____

Client Information

Name: _____
Last Name First Name Middle Name Nickname

Address: _____
Street City State Zip

Home Phone_____ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Work Phone_____ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Cell Phone_____ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Email Address: _____

May I send appointment reminders via email? ☐Yes ☐ No

Date of Birth: _____ Age: Gender: _____

Occupation: _____ _____

Highest Level of Education: _____ _____

Marital Status: ☐ Single ☐ Engaged ☐ Married (how many times?)
☐ Separated ☐ Divorced ☐ Widowed

Spouse/Significant Other Name: _____ Years together: _____

Who currently lives in your home?

Name	Sex	Age	Comments

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Emergency Contact: Whom should we contact in case of an emergency?

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: Anyone else you would want us to contact?

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

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Are you currently in counseling with another therapist? ☐ Yes ☐ No

If "Yes" please do not complete this forms!

Personal Information

How would you rate your overall health?

☐ Very Healthy ☐ Healthy ☐ Average ☐ Needs Improvement ☐ Poor

How many hours do you sleep at night?_____

How would you rate your diet?
☐ Very Healthy ☐ Healthy ☐ Average ☐ Needs Improvement ☐ Poor

How would you rate your level of exercise?
☐ Exercise 5-7 times per week ☐ Exercise 3-4 times per week
☐ Exercise 1-2 times per week ☐ Exercise Occasionally ☐ Never Exercise

Do you have addictive/abusive issues with: ☐Alcohol ☐Illegal Drugs ☐Prescriptions?
☐Sex ☐Pornography ☐Gambling ☐Gaming ☐Other _____ ☐None

Does this affect your everyday life? ☐Yes ☐No ☐Sometimes _____
Explain:

Has your appetite or weight changed lately?_____

Are you currently on medication? ☐ Yes ☐ No If so please complete the following:

Medication	**Dosage**	**Physician**	**Purpose**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any current medical concerns? ☐Yes ☐No

If yes, please explain:

_____

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What brings you to counseling?

What do you hope to gain from counseling?

Have you been to counseling before? ☐ Yes ☐ No If yes, how was your previous counseling experience?

Do you have any current stressors? (illness, divorce, custody, job loss, etc.) ☐Yes ☐ No

If yes, please explain: _____

Do you have any current suicidal thoughts, feelings or actions? ☐Yes ☐No

If yes, please explain_____

Have you ever attempted suicide in the past? ☐Yes☐No
If yes, please provide details_____

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Do you have any current homicidal or assaultive thoughts or feelings or anger control problems? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

_____

_____

How would you rate the intensity of the problem or concern that brought you in today?

1	2	3	4	5
Not Intense		Moderately Intense		Extremely Intense

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1. Life is hopeless.	☐Never	☐Rarely	☐Sometimes	☐Frequently
2. I am lonely.	☐Never	☐Rarely	☐Sometimes	☐Frequently
3. No one cares about me.	☐Never	☐Rarely	☐Sometimes	☐Frequently
4. I am a failure.	☐Never	☐Rarely	☐Sometimes	☐Frequently
5. Most people don't like me.	☐Never	☐Rarely	☐Sometimes	☐Frequently
6. I want to die.	☐Never	☐Rarely	☐Sometimes	☐Frequently
7. I want to hurt someone.	☐Never	☐Rarely	☐Sometimes	☐Frequently
8. I am so stupid.	☐Never	☐Rarely	☐Sometimes	☐Frequently
9. I am going crazy.	☐Never	☐Rarely	☐Sometimes	☐Frequently
10. I can't concentrate.	☐Never	☐Rarely	☐Sometimes	☐Frequently
11. I am so depressed.	☐Never	☐Rarely	☐Sometimes	☐Frequently
12. God is disappointed in me.	☐Never	☐Rarely	☐Sometimes	☐Frequently

13. I can't be forgiven.	☐Never	☐Rarely	☐Sometimes	☐Frequently
14. Why am I so different?	☐Never	☐Rarely	☐Sometimes	☐Frequently
15. I can't do anything right.	☐Never	☐Rarely	☐Sometimes	☐Frequently
16. People hear my thoughts.	☐Never	☐Rarely	☐Sometimes	☐Frequently
17. I have no emotions.	☐Never	☐Rarely	☐Sometimes	☐Frequently
18. Someone is watching me.	☐Never	☐Rarely	☐Sometimes	☐Frequently
19. I hear voices in my head.	☐Never	☐Rarely	☐Sometimes	☐Frequently
20. I am out of control.	☐Never	☐Rarely	☐Sometimes	☐Frequently

Common Problem/Symptoms Checklist: (Please rate 0=none, 1=mild, 2=moderate, 3=severe)

____God/faith	____marriage	____divorce/separation	____alcohol/drugs
____premarital	____child custody	____other addictions	____church/ministry
____singleness	____disabled	____grief/loss	____past hurts
____sexual issues	____work/career	____depression	____codependency
____family	____school/learning	____fear/anxiety	____intimacy
____children	____money/budgeting	____anger control	____communication
____parent	____aging	____loneliness	____self-esteem
____in-laws	____weight control	____mood swings	____stress management

What are your strengths?

_____

_____

_____

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

_____ _____
Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:
I hereby permit and release Troslyn T. Mitchell, LPC to release and furnish all medical and financial da ta related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____
Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent