Adult Intake Packet

CONTACT INFORMATION

Name:	*First* *Middle* *Last*		*Date of birth/age*
Address:	*Street Address* *City* *State* *Zip*		
Home Phone:		May We Leave A Message?	☐ Yes ☐ No
Work Phone:		May We Leave A Message?	☐ Yes ☐ No
Mobile Phone:		May We Leave A Message?	☐ Yes ☐ No
Email Address:		May We Send A Message?	☐ Yes ☐ No
Emergency Contact:	*Name/Relationship* *Phone:*		
What brings you in for counseling?			
Insurance	Company Name ________________________ ID # ____________________________________ Group Number _________________________		

PERSONAL/FAMILY HISTORY

Marital Status: _____ Single _____ Married In a Relationship with ______________________________

Names/Ages of Individuals that live with you

Name	Relationship	Age

Occupation: ____ How many years _________________________

Education: ____

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MEDICAL HISTORY		
Do you have any medical conditions at this time? ☐ Yes ☐ No		
If Yes, Please Explain: ___		
Primary Care Physician ___ Phone ___		
Are you currently taking any prescription medications? ☐ Yes ☐ No		
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
How often do you drink alcohol?	Type:	Times Per Week:
Do you use any other drugs?	☐ Yes ☐ No If Yes, List:	

COUNSELING/PRIOR TREATMENT HISTORY		
	WHEN	REACTION TO OVERALL EXPERIENCE
Counseling/psychiatric		
Suicidal thoughts/attempts		
Drug/alcohol treatment		
Hospitalizations		
Involvement with self-help groups		

SYMPTOMS/COMPLAINTS AT THIS TIME (OR IN THE LAST 3 MONTHS)

Please check behaviors and symptoms that you experience:

	Aggression		Fatigue		Mood shifts
	Anger		Gambling		Panic attacks
	Anxiety		Hallucinations		Phobias/fears
	Avoiding people		Heart palpitations		Recurring thoughts
	Cyber addiction		High blood pressure		Sexual addictions
	Depression		Hopelessness		Sexual difficulties
	Disorientation		Impulsivity		Sick often
	Distractibility		Irritability		Sleeping problems
	Eating disorder		Judgment errors		Suicidal thoughts
	Elevated mood		Memory problems		Worrying

Is there anything else that you would like for me to know:

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WELCOME

The counselors at the New Journey Counseling LLC are happy that you have decided to come in and find out if we can be of service to you. Ohio Counseling Law requires us to provide you with the following information regarding your rights and responsibilities as a client here, and the limits of confidentiality. If you have any questions, feel free to discuss them Dr. Joy A. Wilson, LPCC-SC; RPT-S (513-549-0672).

CLIENT RIGHTS

Clients have the following rights:
A. to be fully informed about a counselor's qualifications, training and experience (please see disclosure form for your counselor).
B. to understand any issue related to treatment or the therapy process.
C. to have the counselor available at the appointment time agreed upon in advance.
D. to discontinue counseling at any time. Should you decide to discontinue, your counselor may request a termination session to discuss progress or areas of continuing concern.
E. to request a change of counselor. Should you feel that you need to change counselors, feel free to discuss that issue with your present counselor or with Dr. Wilson.

CLIENT RESPONSIBILITIES

Clients bear the following responsibilities.
A. to arrive for counseling sessions on time, so the hour (50 minutes) set aside can be utilized maximally.
jtime.
C. If an appointment is cancelled less than 24 hours in advance (other than because of illness or family emergencies) you will be expected to pay $75.00 for the missed appointment.
D. You can pay your fee or copay with a check, credit card, health saving account, or cash. If a person owes for over 3 sessions the client must work out a payment schedule in order to continue sessions.
E. Due to high bank costs, if a client has a check returned we would require cash or credit payment for all future appointments.

LIMITS OF CONFIDENTIALITY

Every effort is made to treat your confidential information in a profession manner in keeping with ethical standards and laws regarding privacy. Please be advised however that there are certain circumstances under which confidential information may be divulged without your express permission.
A. All therapists are required to provide information specified by a subpoena issued by a court of Law; and the results of treatment or tests must be revealed to a court when a client has been ordered into treatment by the court.
B. A therapist may take steps to protect a client or others from imminent danger, when a client threatens physical injury to self or others.
C. A therapist must report disclosures of physical or sexual abuse of a minor to the local children's protective service.
D. A therapist must report disclosures of elder abuse or domestic violence to Adult Protective Services.
E. A therapist must report disclosures of physical or sexual abuse of individuals with disabilities to Child or Adult Protective Services.
F. Your signature below serves as acknowledgment of receipt of our **Notice of Privacy** and **Grievance Procedure** **(which is located on the website: newjourneyc.com or a paper copy provided upon request)**

Client's Signature____ Date_______________

Counselor's Signature_______________________________________ Date_______________