AVENUES OF LIFE

COUNSELING AND COACHING

439 Green Street

Gainesville, GA 30501

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and as carefully as you can. Please use the bottom of the last page for any additional information or comments.

Name_____ Date of Birth_____ Age____ Sex_____

Present Address_____Phone_____
Number Street

_____Cell Phone_____
City State Zip Code

_____
Email address

Marital Status: Single_____ Married_____ (# of Years_____) Divorced_____ Separated _____ Widowed_____

Presently Living With: Parents____ Spouse____ Roommate____ Alone____ Other_____

Family Member to notify in case of Emergency:

Name_____Address_____

Phones_____Relationship_____

Occupation: _____Total Hours worked per week_____

Employed by:_____ Years of Education: _____Phone_____

Referred by: _____

Religious Affiliation_____ Pastors Name _____

Active Member_____ Inactive Member_____ Church You Attend _____

Members of your Family or people in your life:

Relationship	Name	Age	Last Grade Completed	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Describe any physical problems you have that require medication or physical care: _____

_____

Are you currently receiving medical treatment? _____ if so, Doctors name: _____

Health Info: _____

Are you currently taking medications? _____ Please list Medications_____

_____

Previous Counseling/Therapy? _____If yes, when? _____

Where & with whom?_____

Name **Title**

_____

Address **Phone**

Please list your parents (living or deceased) and any brothers or sisters:

Relationship	Name	Age	Last Grade in School	Occupation	How often do you see them?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

_____

_____

Have there been times when the problem got better or disappeared? Yes _____No_____

If so, when?_____

Were there times when the problem was especially bad? Yes _____No_____ Explain_____

_____

Please list any persons you feel may have played a major role in causing your problems_____

_____

Please list any person who helps you cope with your problems_____

_____

Please check the type of counseling you desire:

Individual____ Pre-marital ____ Marital____ Child/Teen_____ Short Term Crisis _____ Family_____ Addiction ____

Group_____ Divorce Recovery_____ Grief/Loss _____ Illness _____ Abuse_____ Domestic Violence_____ Not sure___

Anger Management ____ Stress Management ____ Sexual Issues _____ Emotional Healing _____ Relationships _____

Other_____

Please make a check mark next to each item which identifies an area of concern for you. Place two checks by those items that are most important…

_____Addictions (alcohol, drugs, food, gambling, sex, etc.)

_____Anger

_____Depression

_____Education/Learning Difficulties

_____Eating Difficulties

_____Fearfulness/Anxiety/Panic Attacks

_____Marital Problems

_____Health/Physical Problems

_____Problems with social relationships

_____Financial Problems

_____Mental Health Problems

_____Problems with children

_____Problems with parents

_____Religious/Spiritual Concerns

_____Sexual Concerns

_____Thoughts of Suicide

_____Trouble making Decisions/confusion

_____Unhappy most of the time

_____Addiction of a family member

_____Work/Job related

_____Worry

_____Other (Specify)_____

I, _____ (print your name), have read the policy sheet, completed the intake form, and have submitted to counsel of my own free will. I will not hold Avenues of Life Counseling, or its staff, responsible for the outcome of therapy. (It is my choice to follow the counsel or not)

_____ _____

Signature **Date**

For clients 17 years and under, the signature of his/her guardian or custodial parent is required.

_____ _____

Signature of Parent or Guardian **Date**

Questions, Comments or further information:

_____

_____

_____

_____

AVENUES OF LIFE COUNSELING AND COACHING

Authorization and Consent

Client Name _____ Guardian Name _____

1. **Confidentiality:** Please initial ____ (client/legal guardian or representative)

All communication between client and your Board Certified Counselor is confidential and will not be revealed unless required by law. We are required by law to report child abuse/neglect, major suicidal tendencies, and possible homicides. Your family will not receive any information from us unless you request it. Our files are kept locked. If you want us to discuss your case with someone else you will be asked to sign an "Authorization to Release Information Form." I understand that my counselor may use and disclose the clients' personal health information to help provide health care to the client, to handle billing and payment, and to take care of the other health care operation. We follow the United States HIPPA rulings for privacy.

2. **Cancellation of Appointments:** Please initial ____ (client/legal guardian or representative)

A charge of one-half the regular fee will be billed for the missed session when cancelled within the 24 hour prior to scheduled session or not showing up for session.

3. **Authorization to Release Information to PCP:** Please initial ____ (client/legal guardian)

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care; I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician. I understand this information may include diagnoses, treatment plan, and progress, and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

4. **Consent for Treatment Authorization** Please initial ____ (client/legal guardian)

I authorize and request my counselor and coach to carry out psychosocial assessment, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of

these procedures will be explained to me upon request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my counselor can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such an anxiety, sadness, and anger. I understand that reactions will be worked on between my counselor and me. With these understandings, I hereby authorize treatment for myself. I give permission to develop treatment and/or provide treatment. In the event that I become ill or I am injured while on the premises, I authorize my counselor to provide/obtain emergency medical services (i.e. call an ambulance/911).

Initial ____Signature of Client/Legal Guardian_____ Date _____

AVENUES OF LIFE COUNSELING AND COACHING

Debit/Credit Card Authorization Form

PLEASE COMPLETE THIS CONFIDENTIAL AUTHORIZATION

Cardholder Name: _____

Billing Address: _____Zip Code_____

Email Address: _____

Credit Card Type: _____ Visa _____ MasterCard _____ Discover _____ Am Ex

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

I authorize_Avenues of Life Counseling and Coaching 439 Green Street Gainesville, Ga. 30501 to charge my outstanding invoice for sessions.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Print Name: _____

Date: _____