



AVENUES OF LIFE COUNSELING AND COACHING

Elizabeth Evans, RN
Board Certified Pastoral Counselor
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.

How did you find out about Avenues of Life Counseling and Coaching: (circle one)

Avenues of Life website Facebook Google maps Psychology Today Yelp Google search word of mouth other

Please share who we can thank if word of mouth or other _____

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 _____ Pastor's Name _____

Active Member _____ Inactive Member _____ Church You Attend _____

Members of your Family or people living with you:

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...

- | | |
|--|---|
| <input type="checkbox"/> Addictions (alcohol, drugs, food, gambling, sex, etc.) | <input type="checkbox"/> Problems with children |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Problems with parents |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Religious/Spiritual Concerns |
| <input type="checkbox"/> Education/Learning Difficulties | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Eating Difficulties | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Fearfulness/Anxiety/Panic Attacks | <input type="checkbox"/> Trouble making Decisions/confusion |
| <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Health/Physical Problems | <input type="checkbox"/> Addiction of a family member |
| <input type="checkbox"/> Problems with social relationships | <input type="checkbox"/> Work/Job related |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Mental Health Problems | <input type="checkbox"/> 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:



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Client Name _____ Guardian Name _____

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

All communication between client and counselor Elizabeth Evans Board Certified Pastoral 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 as 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, Elizabeth Evans to provide/obtain emergency medical services (i.e. call an ambulance/911).

Initial ____ Signature of Client/Legal Guardian _____ Date _____



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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: _____