NEW HOPE
COUNSELING CENTER
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35037 Royal Place * Soldotna, AK 99669 * (907) 260-7423

CLIENT INFORMATION FORM
Adult/Adolescent

Client Name: ____
First MI Last

Mailing Address: ____

Residential Address: ____
Address City State Zip Code

To respect your privacy, please provide a confidential phone number:
Home Phone: ________________ Cell: _________________ Email Address: ___________________

Social Security Number: ___________________ Birth date: _________________

Gender: _____Male ___Female

Employer: ______________________________ Occupation: ___________________________________

How did you hear about us? ____

Emergency Contact: ____________________________ Phone: _______________________________

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company Name: ___________________	Insurance Company Name: ___________________
Insurance ID#: ___________________________	Insurance ID#: ___________________________
Group #: ______________	Group #: ______________
Insurance Policy Holder: _____________________	Insurance Policy Holder: _____________________
Policy Holder Date of Birth: _______________	Policy Holder Date of Birth: _______________
Policy Holder Mailing Address: _____________	Policy Holder Mailing Address: _____________
Policy Holder Employer: ____________________	Policy Holder Employer: ____________________

MULTIPLE INSURANCE COVERAGE – *For those with more than one insurance coverage, due to cost and time constraints,* ***we are only able to bill your primary insurance****. However, we will be happy to assist you by providing you information so that you may submit a claim to your secondary insurance company.* ***Should Secondary Insurance Companies only submit checks to NHCC, we will reimburse clients once ALL Secondary Insurance funding has been received****.*

Please remember that insurance is a contract between you and your insurer. We are happy to help as much as we can to ensure payment of your benefits, however, we cannot, and will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or what insurance companies refer to as, "usual and customary" reductions (initial _____).

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Employee Assistance Program (EAP) Information

EAP Employer Name: ________________________________ EAP Provider Name: ________________________

Number of Sessions: _________ Approval Code/Conformation#: _____________________________________

EMPLOYEE ASSITANCE PROGRAMS (EAP) - *New Hope Counseling Center counselors are credentialed with many Employee Assistance Programs. In order to utilize this service, you must provide the NHCC Office Administrator with the name of the EAP and the authorization number* ***on or before the first visit****. If verification is not provided by the first appointment, then your private insurance company will be billed at the full intake hourly rate. If you are not insured, the administrative discount for paying out of pocket will apply, and you will be responsible for payment at time of service. (initial ____.)*

Other Compensation

Is your condition related to:

1. Employment? (current or previous) ___Yes ___No *2. Auto Accident?* ___Yes ___No

3. Other Accident? ___Yes ___No

If yes to any of the above,
Date and Location of Claim: ____

____

I understand that payment for all treatment received is my responsibility. I hereby authorize the release of any information to my insurance company that is required to process a claim on my behalf, including, but limited to, insurance appeal rights on my behalf. I also herby authorize my insurance company to remit payment for any behavioral health benefits due directly to New Hope Counseling Center. These authorizations shall expire in one year, or upon my written notice.

Signature of Responsible Party: _______________________________________ **Date:** ________________________

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Adult Intake Questionnaire

In order for us to best serve you, it is extremely helpful if we have some background information regarding your situation. Please answer all questions to the best of your ability.

Client's Name: ______________________________ **Client's Date of Birth**: ________________________

Family History

Your birth order (circle) 1 2 3 4 5 6 7

Marital History: ____

Current Marital Status: ___Single ___Engaged ___Married ___Separated
___Divorced ___Single w/children ___Married w/children
___Widowed

Ages of your children: ___ ___ ___ ___ ___ ___ ___

Are you living with your spouse/partner? ___Yes ___No

Current living situation: ___ Excellent ___ Good ___ Fair ___ Poor

Occupation: __________________

Military History: ____

Religious Preference: ____

Cultural Background/Cultural Concerns: ____

Please describe any special circumstances of which you feel your counselor should be aware:

____

Prior Counseling:

Have you previously sought counseling? ___Yes ___No
Longest treatment by: ____________________ Number of sessions: _________
From ______ To______

Medical History:

Describe Current Health Status: ___Excellent ___Good ___Fair ___Poor
How long has it been since your last physical exam? _____________________

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Medical History Cont.
:
Do you have a history of any of the following?

___ Tuberculosis ___ Heart Disease ___Birth Defects ___ High Blood Pressure

___ Alcoholism ___ Drug Abuse ___Diabetes ___Emotional Problems

___ Cancer ___ Thyroid Problems ___ Stroke ___ Behavior Problems

___ Alzeimer's Disease/Dementia ___ Learning Disability ___ Pain Mainagement

___ Other Chronic or Serious Health Problems ____

Known Allergies: ____

Current medical conditions: ____

Name and Clinic/Office of Primary Care Physician:____

Name of Physician who does medication management (if any): ____

Current prescribed medications for medical or mental health conditions:

Medication	Dosage	Date	Reason

Prior medications for treatment of mental health conditions: ___ Yes ___ No

Medication	Approximate Length of Use	Dosage	Effective?
			Y N
			Y N
			Y N

Prior inpatient (hospitalization) for a mental health issue? ____ Yes ____ No
If yes, on how many occasions? ________ Where? ______________________________________
Longest treatment at: __________________________________ From: ____/____ to _____/_____
Has any family member ever had inpatient treatment for a psychiatric, emotional, or substance abuse disorder? ___ Yes ____ No

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Chemical Use

Prior Use: ___Yes ___No Current Use: ___Yes ___No Date of Last Use:_____________

Substance	Frequency of Use	Amount	Length of Use

Longest Period of sobriety: ____
Prior Substance Abuse Treatment With: ________________________ From: ____/____ to _____/_____

Childhood Health:

Immunization Status: ____ Current ____ Not Current ____ Unknown

List any significant injuries or health issues: ____

List any chronic, serious health problem: ____

List any history of head injuries: ____

Developmental History **Check the word(s) that apply:**

Developmental milestones of walking, talking, toilet training, reading:
__Early __On Time __Delayed

While pregnant, mother used: __ Alcohol __Drugs __Both __N/A

Client started school: __Early __On Time __Late

Check the word(s) that apply:

Educational course: __ Uneventful __Held back a grade __Skipped a class
__Skipped many classes __Took honors classes __Advanced a grade

Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 5 6 7
G.P.A:_____

Right or Left handed: __Right __Left

Thought processing: __racing __ pressured __intrusive __obsessive __non-pressured

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Predominant Mood: (pick all that apply) __anxious __depressed __happy
__sad __fearful __manic __just so-so __flat

Rate severity for each (1-10) ____

Appetite: __good __poor __fair __intense

Weight: __stable __loss __binging __binging/purging __gain

Experience of: __moderate exercise __pleasurable activities
__pre-occupation with pleasurable activities __inability to have fun
__stable enjoyable sex life __diminished interest in activities

Sleep: Number of hours/night:____ ___restful ___unrestful
General sleep schedule: From ______ to ______

Waking up: ___frequent ___infrequent ___very infrequent
___mid-sleep disruption ___late or early disruption
Experience of: ___nightmares ___night terrors ___repeating dreams
___recurrent nightmares ___insomnia ___euphoria ___extended agitation

Socialization: __several active friends __little social contact
__fair with a few friends

LeisureInterests:____

Do you hear voices? ___Yes ___No
Do faces ever seem distorted? ___ Yes ___ No
Do colors ever seem too bright or too dull? ___ Yes ___No
Have you ever felt people were watching you? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No When:______________________
Please explain the history of what happened: ______________________________________
____

Suicidal/homicidal ideation: Do you currently have a plan for self-harm or harm to others?
___Yes ___No
Please explain:____
____

3 - Object recall (Completed with counselor: ____)
W-O-R-L-D (Completed with counselor: ____)

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Rate the items with which you are currently having problems. Circle the number that best indicates the severity of the problem.

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

Circle the word(s) in brackets that best define(s) each statement:

Anxiety (Worry) (Fear) (Panic) (Phobia)	0 1 2 3 4
Feelings of (Depression) (Sadness)	0 1 2 3 4
Thoughts of (Death) (Suicide)	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Mood Swings	0 1 2 3 4
Grief over (Death of Loved One) (Major Loss)	0 1 2 3 4
Issues Related to (Pregnancy) (Abortion)	0 1 2 3 4
Abuse (Physical) (Domestic) (Emotional) (Ritual)	0 1 2 3 4
Sexual Abuse (Incest) (Rape)	0 1 2 3 4
Parent(s) had (Alcohol) (Drug) Problem(s)	0 1 2 3 4
Marriage Problems	0 1 2 3 4
Relationship Problems with Children	0 1 2 3 4
Problems with (Parents) (Family)	0 1 2 3 4
Problems (Work) (School) (Legal)	0 1 2 3 4
Sexual (Concerns) (Problems)	0 1 2 3 4
Problem (Alcohol) (Drugs) (Smoking) (Other)	0 1 2 3 4
Feelings of (Hopelessness) (Helplessness) (Despair)	0 1 2 3 4
Memory (Forgetfulness) (Changes)	0 1 2 3 4
Sexual Orientation	0 1 2 3 4

In your own words, state the concerns that bring you to counseling:

____

____

____

To the best of my knowledge, the information provided is accurate and true.

Signature: ______________________________________ Date: ___________