SOARING to FREEDOM
CHRIST-CENTERED COUNSELING

Adult Contact Information

Date: _____/_____/_____
(mm/dd/yyyy)

First Name: _____ Middle Name: _____ Last Name: _____

Nickname: _____ Gender: _____ Birthdate: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Marital: 1 Single 1 Married 1 Living as Married 1 Divorced 1 Separated 1 Widowed

Race/Ethnicity: *(Check all that apply)*
Asian/Pacific Islander | African-American/Black | Native American
White/Caucasian | Latino/Hispanic | Decline to specify

Primary Care Provider

PCP Name: _____ PCP Group *(if applicable)*: _____

PCP Phone #: (____) ____-____ Fax #: (____) ____-____

Contact Phone Numbers

Check Primary			OK to leave messages? Yes	No
c	Home:	(____) ____-____	c	c
c	Work:	(____) ____-____	c	c
c	Cell:	(____) ____-____	c	c

Spouse/Partner: _____ Phone: (____) ____-____

Emergency Contact Information

Name: _____

Address: _____

Phone: (____) ____-____ Relationship to you: _____

Name: _____

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Mental Health Information

In the past two weeks, how often have you experienced the following? Please select your answers.

	None/Rarely	Sometimes	Often
Felt little interest or pleasure in doing things, especially what you used to enjoy?			
Felt down, depressed or hopeless?			
Felt nervous, anxious or scared?			
Not been able to stop or control worrying?			
Had problems paying attention when at work or completing a project?			
Fidgeted or squirmed with hands or feet when you had to sit for a long time?			
Checked, touched or counted things even though you know you don't have to?			
Done things over and over a certain number of times before they seem right?			
Restricted your food intake, ate more than normal or regurgitated your food?			
Worried about your appearance or weight?			
Had thoughts about killing or hurting yourself?			
Had thoughts about hurting someone else?			
Been threatened or hurt by someone else?			

	Yes	No
In the last six months, have you gambled?		
If yes, please answer the following:		
Have you felt the need to bet more and more money?		
Have you ever had to lie to people about how much you have gambled?		

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Name: _____

In the last year, have you... **None** **Some** **Often**

For women: Had more than 3 drinks in a day or 7 drinks in a week?

For men: Had more than 4 drinks in a day or 14 drinks in a week?

SUBSTANCE TYPE	LAST 12 MONTHS				PRIOR USE			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Alcohol	○	○			○	○		
Caffeine	○	○			○	○		
Marijuana/Cannabis	○	○			○	○		
Tobacco	○	○			○	○		
Hallucinogens	○	○			○	○		
Inhalants	○	○			○	○		
Opioids (pain pills, heroin)	○	○			○	○		
Hypnotics / Sedatives	○	○			○	○		
Stimulants (meth, cocaine)	○	○			○	○		

In your life, have you experienced the following? Please select your answers. **Yes** **No**

Someone expressed concern about your alcohol or drug use? .....

Your alcohol or drug use led to social, financial or employment problems? .....

Have you for at least a week, felt especially energetic with little need for sleep? .....

In that same week, did things that others considered foolish or risky with money, sex or other activities? .....

In your life, have you had any experience that was so frightening, horrible or upsetting that you

had nightmares or thought about it when you didn't want to? .....

tried hard not to think about it or avoided situations that reminded you of it? .....

were constantly on guard, watchful or easily startled? .....

felt numb or detached from others, activities or your surroundings? .....

Please check if you have experienced any of the following types of trauma or loss.

Emotional abuse
Sexual abuse
Physical abuse
Loss of a loved one
Bullying
Neglect
Homelessness
Crime victim
Parent illness
Lived in a foster home
Multiple family moves
Violence in the home
Parent substance abuse
Immigration Trauma
Human trafficking
Gang violence
Witnessed death

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Name: _____

Medical Information

Month/year of last physical exam: _____/_____ Physician: _____

Do you have any chronic medical conditions?..... **Yes** **No**

If yes, please list. _____

Do you have any CURRENT health concerns?..... **Yes** **No**

If yes, please list. _____

Current prescription medications: None

MEDICATION	DOSAGE	DATE FIRST PRESCRIBED	PRESCRIBED BY

Current over-the-counter medications (including vitamins, herbal remedies, etc): _____

_____

Do you have allergies and/or adverse reactions to medications? **Yes** **No**

If yes, please list. _____

Family and Developmental History

Please list the individuals in your family. Continue on the back of this page, if needed.

NAME	RELATIONSHIP TO YOU	AGE	LIVES WITH YOU?	QUALITY OF RELATIONSHIP	MENTAL HEALTH DIAGNOSIS?

Additional Notes:

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Name: _____

Social/Cultural Information

Do you have challenges finding support (from family, friends, etc.)? ..... **Yes** **No**

Are you experiencing any difficulties or concerns due to race, culture, sexual orientation, gender, gender identity, age or ethnic issues? ..... **Yes** **No**

If yes, please describe. _____

_____

Sexual Orientation (optional): _____

Please describe your spirituality, religion, or worldview. _____

_____

Please list your strengths, skills and talents. _____

_____

_____

List any special areas of interest or hobbies (art, books, physical fitness, etc.). _____

_____

_____

Employer: _____ Position: _____

Length of time in this position: _____ Previous jobs: _____

_____

Highest level of education completed: _____

Are you currently enrolled in a school or training program? ..... **Yes** **No**

If yes, please list. _____

Have you ever been convicted of a misdemeanor or felony? ..... **Yes** **No**

If yes, please explain. _____

_____

Are you currently involved in any divorce or child custody proceedings? ..... **Yes** **No**

If yes, please explain. _____

Please describe any additional information or concerns you feel your provider should know.

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Adult Intake Form

Name: _____ Date: _____

Presenting Problem and Treatment Planning

Describe the problem that brought you here today. _____

_____

_____

_____

When did you first notice this problem? _____

_____

_____

Describe any treatment you have tried for this problem or other problems.

Type	WHEN (start – finish)	WHERE	WHY
Outpatient Counseling			
Medication (mental health)			
Psychiatric hospitalization			
Drug/alcohol treatment			
Self-help/support groups			

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Treatment Process

Services at Soaring to Freedom start with an assessment. Your counselor will talk with you about your current situation, ask you about your history, and make a recommendation for services. You will then develop a "treatment plan" together that outlines how services will go and what outcomes are expected.

Individual sessions usually last 20–30 minutes. They may be weekly or less than weekly. The frequency of sessions will likely decrease over time. Your clinician will talk with you about what is recommended for you.

If you and your counselor believe that psychiatric medications might be helpful, your clinician can make a referral to your family physician.

Risks & Benefits

Mental health services are generally effective in treating most mental health conditions. We review outcomes and find that most people benefit from therapy and/or medications. Few people get worse ffrom treatment. Improvements do require attending appointments and following through with recommendations.

When we develop a treatment plan with you, we will discuss risks and benefits more.

Minor Consent

Anyone under the age of 18 years must have parental consent for counsel, unless they have made previous arrangements with counselor and have written documents to attest to their personal accountability.

Rights & Responsibilities

We recognize the following rights:

- Be treated with dignity and respect. Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability.

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ACKNOWLEDGEMENT OF INFORMED CONSENT, RIGHTS & RESPONSIBILITIES, COMPLAINTS PROCESS, AND PRIVACY POLICIES

Print Client Name: _____ Client Date of Birth: _____

If Parent/Guardian, print name: _____ Parent Guardian

Informed Consent INITIAL

I have read and understand the risks & benefits related to treatment and evaluation by Soaring to Freedom. I consent to receive mental health services by Soaring to Freedom. Any questions I have regarding these have been answered.

Rights & Responsibilities and Complaints/Grievances INITIAL

I have reviewed and understand my rights and responsibilities and the Complaint/Grievance process for services at Soaring to Freedom. This includes complaints, fees, no-show/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions on these have been answered.

Notice of Privacy Practices INITIAL

I have reviewed Soaring to Freedom's privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. I understand that Soaring to Freedom will share basic information with my primary care provider unless I ask to "restrict" this disclosure.

Financial INITIAL

If I cancel within 24 hours or do not show for an appointment, I will pay $35. I am the, financial guarantor", meaning I will be responsible for payment.

Signature of Client or
Parent/Guardian: _____ Date: _____