Alfrey & Pruitt
Counseling Services

NEW CLIENT INTAKE - ADULT

For us to serve you better, please fill out your information as completely as possible to the best of your knowledge.

PERSONAL INFORMATION	Birthdate (mm/dd/yyyy):	Age:
PERSONAL IDENTIFIERS	Sex at Birth: ☐ Male ☐ Female ☐ Intersex	Pronouns:
	Gender: ☐ Male ☐ Female ☐ Trans ☐ Questioning ☐ Nonconforming ☐ Prefer not to answer ☐ Other:	

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic / Latino ☐ Black or African American ☐ White/Caucasian ☐ Other:	Ethnic Background: ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Dominican Rep ☐ Non-Hispanic/Latino ☐ Other Hispanic

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Sudanese ☐ Vietnamese ☐ Other:

How did you hear about us (referral source)?

NAME	First name:	MI:
	Last Name:	
ADDRESS	Street:	Apt/Unit:
	City:	State:
	Zip code:	County:
CONTACT INFORMATION	Home phone:	
	Cell phone:	
	Email:	
CONTACT REQUESTS	I Would Like Appointment Reminders by: ☐ Email ☐ Text ☐ Phone Call	

CONSENT TO CONTACT

By signing below, I hereby give Alfrey and Pruitt Counseling Services my permission to contact me by mail, phone, email, text, or voicemail regarding appointments and account information.

_____ _____

Client and/or Parent/Guardian Signature Date

SERVICE INFORMATION
Check which service(s) you would like to receive: ☐ Outpatient counseling
Why are you seeking services (check all that apply):

☐ Alcohol/Drug	☐ Relationship / Marital Problems	☐ Trauma/Abuse
☐ Domestic Violence	☐ Suicidal Thoughts and/or Attempts	☐ Depression
☐ Bipolar	☐ Anxiety	☐ Other:

INSURANCE PLAN INFORMATION	
Primary Plan Name:	Policy Number:
	Group Number:
Policy Holder's Name:	Birthdate (mm/dd/yyyy):
	Social Security Number:
Policy Holder's Employer:	Relationship to Client:
Secondary Plan Name:	Policy Number:
	Group Number:
Policy Holder's Name:	Birthdate (mm/dd/yyyy):
	Social Security Number:
Policy Holder's Employer:	Relationship to Client:
Are you eligible for any of the following benefits? ☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare	
Are you receiving any of the following benefits? ☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare	

Alfrey and Pruitt Counseling Services Requires Insurance and Probation Voucher Copays to be Paid on the Date of Service.

Copayment Amount: $_____

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

_____ _____

Client and/or Parent/Guardian Signature Date

** Please note that a copy of your current insurance card is required at the time of service.

RELEASE TO INSURANCE
My signature authorizes the release of any pertinent information to a third-party payer, if applicable, and assigns benefits to Alfrey and Pruitt Counseling Services. I understand that payment is required at the time of each visit unless other arrangements have been made in advance. I also understand that I will be responsible for any copays or other charges that are not otherwise covered by insurance. The fee has been explained to me and my signature authorizes Alfrey and Pruitt Counseling to provide services to the person listed as the client. Prompt payment is required, and past due accounts are subject to collection.

_____ _____

Client and/or Parent/Guardian Signature Date

CANCELLATION AND NO-SHOW POLICY
To continue providing responsive and quality care to our community, Alfrey and Pruitt Counseling requires the cancellation of any appointment to occur at least 24-hours in advance. Individuals who miss their scheduled appointments, without prior notification, will be considered a "No Show." Arriving more than 15 minutes late to a scheduled appointment will also constitute a "No Show". Any late cancellation or "No Show" may lead to the forfeit of any regularly scheduled timeslot (e.g., weekly, biweekly, etc.). Two (2) or more late cancellations or "No Shows" in a three (3) month period may result in the termination of services and/or the denial of future appointments; in these instances, a $50 late-cancellation fee will be charged when applicable. _____ _____ Client and/or Parent/Guardian Signature Date

EMERGENCY CONTACT	Relationship to Client:	
NAME	First name:	Last Name:
CONTACT INFORMATION	Phone:	
	Street:	Apt/Unit:
	City/State:	Zip code:

PARENT / LEGAL GUARDIAN (For clients under 19 years of age, elderly, mentally disabled, etc.)		
Parent / Guardian Name (First, MI, Last):		
Relationship to Client:		
Street Address:		Apt/Unit:
City:	State:	Zip code:
Home Phone:	Work Phone:	
Cell Phone:	Email:	

EMPLOYMENT / DEMOGRAPHIC INFORMATION		
Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Retired		
Employer:		
Street Address:		Office/Unit:
City:	State:	Zip code:
Work Phone:	Annual Household Income: $	
Income Sources: ☐ Employment ☐ Public Assistance ☐ Retirement/Pension ☐ Disability ☐ Other:		
Living Structure: ☐ Family's Home ☐ Relative's Home ☐ Group Home ☐ Living with Others		

☐ Foster Care Home ☐ Residential Treatment Center ☐ Shelter ☐ Homeless ☐ Hospital ☐ Other:	
Number of Dependents:	Are you a veteran?

CONSENT TO TREATMENT
I hereby consent to health care treatment provided by Alfrey and Pruitt Counseling Center. This includes assessment and treatment procedures, as appropriate. I understand that treatment options will be discussed with me, and I have a right to participate in decisions about my treatment. _____ Client Name (printed) _____ _____ Client Signature Date _____ _____ Parent/Guardian Signature Date

MEDICAL HISTORY
How would you describe your physical health? ☐ Good ☐ Fair ☐ Poor
How would you describe your mental health? ☐ Good ☐ Fair ☐ Poor
Have you received any prior outpatient mental health treatment? ☐ Yes ☐ No
If so, when, where, and what was the focus of treatment?
Have you received any prior inpatient mental health treatment and/or been hospitalized for mental health reasons? ☐ Yes ☐ No
Please list any prior mental health diagnoses:
Do you have problems eating? ☐ Too Much ☐ Not Enough ☐ No
Have there been any noticeable weight changes? ☐ Loss ☐ Gain ☐ No
Do you have problems sleeping? ☐ Too Much ☐ Not Enough ☐ No
Please list any current medications:
List any known medication allergies:

INITIAL SCREENING FOR SELF-HARM POTENTIAL		
Was there a potentially lethal suicide attempt in the past 24 hours?	☐ Yes	☐ No
Are there statements of intent to self-harm?	☐ Yes	☐ No
Is there a plan for self-harm?	☐ Yes	☐ No
Are you unwilling and unable to agree NOT to self-harm?	☐ Yes	☐ No
Are you experiencing auditory hallucinations that command self-harm?	☐ Yes	☐ No

SELF-ADMINISTERED SCREEN FOR ALCOHOL AND/OR DRUGS		
During the past 12 months have you stopped smoking cigarettes for one day or longer because you are trying to quit?	☐ Yes	☐ No
How long has it been since you last smoked a cigarette, even one or two puffs? ☐ Within the past 24 hours ☐ Within the past 3 days ☐ Within the past week ☐ Within the past month ☐ Within the past 3 months ☐ Within the past 6 months ☐ Within the past year ☐ More than one year ago ☐ Don't now/not sure ☐ Never smoked		
Does anyone in your home smoke tobacco in the house?	☐ Yes	☐ No
1.) Have you ever used any alcohol or other drugs? ***(if no, skip to question 14)***	☐ Yes	☐ No

Substance	**Last Time of Use**	**Used in the Last Month? How Much?**	**Date or Age of First Use?**	**Form of Use? Smoking, Oral, Injection?**	**Average Amount of Use**	**Most Used Amount**	**Problems Occurred During Use (Law, Work, Health)**
Alcohol							
Cocaine							
Marijuana							
Heroin							
Opium / Synthetics							
Methamphetamine							
Hallucinogens (LSD or Shrooms)							
Benzodiazepines							

Substance	Last Time of Use	Used in the Last Month? How Much?	Date or Age of First Use?	Form of Use? Smoking, Oral, Injection?	Average Amount of Use	Most Used Amount	Problems Occurred During Use (Law, Work, Health)
Barbiturates							
Inhalants (huffing)							
Nicotine							
Other Including Prescriptions or over the counter drug abuse							

SELF-ADMINISTERED SCREEN FOR ALCOHOL AND/OR OTHER DRUGS OVER THE PAST 12 MONTHS		
1.) Have you used alcohol or other drugs in the past 12 months?	☐ Yes	☐ No
2.) Do you feel that you have used too much alcohol or other drugs?	☐ Yes	☐ No
3.) Have you tried to reduce or stop drinking alcohol or other drugs?	☐ Yes	☐ No
4.) Have you received help to stop drinking alcohol or other drugs? *(Example AA, NA, Outpatient or Inpatient Treatment)*	☐ Yes	☐ No
5.) Have you had health problems from alcohol or other drugs?	☐ Yes	☐ No
6.) Have you ever: *(check all that apply)* ☐ Had fainting or memory loss ☐ Have you hurt yourself after drinking alcohol or other drugs? ☐ Have you had seizures? ☐ Do you have hepatitis or other liver problems? ☐ Have you felt sick, shaken, or depressed when you stop using alcohol or other drugs? ☐ Have you felt bugs under the skin when you stop using alcohol or other drugs? ☐ Have you used syringes for drugs?		
7.) Does drinking alcohol or using other drugs hurt you at school or work?	☐ Yes	☐ No
8.) Have you been arrested or had other legal problems due to use of alcohol or other drugs?	☐ Yes	☐ No
9.) Have you ever been angry or quarreled when you have been under the influence of alcohol or other drugs?	☐ Yes	☐ No
10.) Do you have to drink or use more alcohol or other drugs to get the effect you want?	☐ Yes	☐ No
11.) Do you keep thinking to much about how to get alcohol or other drugs?	☐ Yes	☐ No
12.) When you use alcohol or other drugs do you do things you normally would not do?	☐ Yes	☐ No
13.) Do you feel bad or guilty about using alcohol or other drugs?	☐ Yes	☐ No
The following questions are about the experience of your whole life.		

14.) Have you had problems with alcohol or other drugs?	☐ Yes	☐ No
15.) Has your family had problems with alcohol or other drugs?	☐ Yes	☐ No
16.) Do you feel bad or guilty about using alcohol or other drugs?	☐ Yes	☐ No

Your therapist will complete this section.

Items 1 and 14 are not scored. The following items are scored as 1 (yes) 0 (no):

___ 2	___ 5	___ 8	___ 11	
___ 3	___ 6	___ 9	___ 12	
___ 4	___ 7	___ 10	___ 13	___ Total Score

(score range 0-12)

Score		Degree of Risk for AOD Abuse (Preliminary Interpretation of Responses)		
0-1	none to low	2-3	Minimal	4 & > Moderate to high, possible need for further assessment

TRAUMA HISTORY Have you ever experienced any of the following?			
Sexual Abuse	☐ Yes	☐ No	☐ N/A
Sexual Assault / Rape	☐ Yes	☐ No	☐ N/A
Prostitution and/or sex trafficking	☐ Yes	☐ No	☐ N/A
Physical abuse	☐ Yes	☐ No	☐ N/A
Physical assault	☐ Yes	☐ No	☐ N/A
Witnessed domestic violence	☐ Yes	☐ No	☐ N/A
Neglect	☐ Yes	☐ No	☐ N/A
Emotional abuse	☐ Yes	☐ No	☐ N/A
Victim of a crime	☐ Yes	☐ No	☐ N/A
Victim and/or witnessed community violence	☐ Yes	☐ No	☐ N/A
Serious accident and/or injury	☐ Yes	☐ No	☐ N/A
Life-threatening medical issue	☐ Yes	☐ No	☐ N/A
Traumatic loss	☐ Yes	☐ No	☐ N/A
War / Political Violence / Torture	☐ Yes	☐ No	☐ N/A
Serious Natural Disaster (Tornado/Earthquake/Fire)	☐ Yes	☐ No	☐ N/A
Institutionalized	☐ Yes	☐ No	☐ N/A

COMMUNITY SERVICES INFORMATION

*Are you receiving case management from Health and Human Services or another agency?	☐ Yes	☐ No
If so, please list the caseworker's name and contact information:		
*Will any other person be significantly involved in your mental health treatment / counseling sessions (spouse, social worker, caregiver)?	☐ Yes	☐ No
If so, who?		
Are you receiving court / legal / probation services?	☐ Yes	☐ No
If yes, why (drug court, state ward, probation, other):		
*Are you court ordered to receive outpatient mental health treatment?	☐ Yes	☐ No
If yes, who is the primary court / probation contact (name, number, and/or email)?		
Have you ever received Special Education Services?	☐ Yes	☐ No
If yes, why (reading, math, extra time on tests, separate testing environment, etc):		