Adult Intake Assessment

Client Name: _____

Age _____Date of Birth _____Gender: ☐ **Male** ☐ **Female** ☐ _____

Address_____

City_____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____

Work Phone _____ **May We Leave a Message?** _____

Relationship Status: *Check which one applies to you.*

☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Name of Spouse or Partner: _____

If married, years married to present spouse: _____

Number of previous marriages and how long married: _____
_____

Number of Children:

Name	Age	Gender

Who lives in your home? _____
_____

Email Address: _____@_____

May we add you to the email newsletter list? ☐ Yes ☐ No

In case of an emergency, *Sycamore Wellness Group, LLC* has permission to contact:

Name _____ Phone Number _____

Address _____

Please indicate who referred you to the Sycamore Wellness Group, LLC

Referral Type:

☐ Self-referral ☐ Friend ☐ Employee Assistance Program (EAP) ☐ Healthcare Insurance

Healthcare Insurance Information

Name of Healthcare Insurance_____

Billing Address _____
(Information is found on the back of insurance card)

_____Phone Number _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's home address: _____
(If different than client's address above)

_____

Client's relationship to policy holder:

☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Number _____ Group Number _____

Employer's Name _____

Authorization Number _____ Approved Number of Sessions _____

Employee Assistance Program (EAP) Information

Name of EAP Company _____

Billing Address _____

_____Phone Number _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's home address: _____
(***If different than client's address above***)

_____

EAP Information Continued…….

Client's relationship to policy holder:

☐ Self ☐ Spouse ☐ Child ☐ Other

Employer's Name _____

Authorization _____ Approved Number of Sessions _____

What is your Religious Affiliation? _____

Do you desire to have your religious beliefs and values incorporated into the counseling sessions?

☐ Yes ☐ No ☐ Not Sure ☐ Not Applicable

MEDICAL HISTORY

If yes, please list	**Do you have any medical illnesses?** ☐ Yes ☐ No		
	Medical Condition		*Year diagnosed*
HOSPITALIZATIONS			
Year	*Reason*	*Hospital*	

List your *prescribed medication* and *over-the-counter medication*		
Name of Medication	*Dosage*	*Frequency Taken*
Allergies		

HEALTH HABITS

Exercise	☐ Sedentary (No Exercise)				
	☐ Mild exercise (i.e., climb stairs, walk, golf, etc.)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or exercise 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	Number of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Have you received treatment for drug or alcohol problems?			☐ Yes	☐ No
	If yes, what year? How long was your treatment?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes	Amount per day?	# of years using?		Year quit
	☐ Chew	Times per day?	# of years using?		Year quit
	☐ Pipe	Times per day?	# of years using?		Year quit
	☐ Cigars	Times per day?	# of years using?		Year quit
Drugs	Do you currently use recreational/street drugs?			☐ Yes	☐ No
	If yes, what type? How often?				
	Do you need a ***referral*** for substance abuse counseling?			☐ Yes	☐ No

If you want *Sycamore Wellness Group, LLC* to collaborate with your doctor(s), please complete their information below and ***sign a Release of Information form***.

Name and address of your ***Primary Care Physician****:* _____

_____

Physician Phone Number _____Fax Number _____

Name and address of your **P*sychiatrist***: _____

_____

Psychiatrist Phone Number _____ Fax Number _____

SYMPTOM CHECKLIST

Please check all of the following symptoms experienced in the past "Six Months"

☐ Repetitive, senseless thoughts	☐ Repetitive, senseless behaviors
☐ Tremors, trembling or shakiness	☐ Seizures
☐ Skin rash	☐ Violent behavior
☐ Constant worry	☐ Irritability
☐ Tension	☐ Headache
☐ Feeling in a dreamlike state	☐ Fearful feelings
☐ Fear of losing control	☐ Jumpiness
☐ Restlessness	☐ Sweating
☐ Dizziness/lightheadedness	☐ Keyed up/on edge
☐ Agitation	☐ Nervousness
☐ Trouble concentrating	☐ Insomnia/trouble sleeping
☐ Decrease in sex drive	☐ Trouble making decision
☐ Sad/depressed/down in the dumps	☐ Lack of/loss of interest in things
☐ Helpless feelings	☐ Fatigue, lack of energy
☐ Weakness	☐ Increase or decrease in appetite
☐ Increase or decrease in weight	☐ Frequent crying or weeping
☐ Frequent thoughts of death or suicide	☐ Worthless feelings
☐ Excessive feelings of guilt	☐ Hopeless feelings
☐ Feeling life is not worth living	☐ Sleeping too much
☐ Frequent negative thinking	☐ Memory problems
☐ Fear of doing something uncontrollable	☐ Fear of dying
☐ Chills	☐ Seeing or hearing things that are not real
☐ Fear of going crazy	

What is your main reason for this visit? _____
_____

Will you need paperwork completed for the following?

☐ **Family Medical Leave Act (FMLA)** ☐ **Short-term/Long-term Disability**

☐ **Court or Legal**

*****If you need the counselor to complete any paperwork, additional fees apply*****

List any *hobbies, talents or special interests* you have. _____
_____

List your personal *strengths*. _____
_____

List any personal areas that are *limitations*. _____
_____

List how you currently *cope with stress*. _____
_____

INFORMED CONSENT FOR PSYCHOTHERAPY

I, _____give permission to *Sycamore Wellness Group, LLC, and clinical staff members* to provide me with psychotherapeutic services. ***The standard meeting time for psychotherapy is 50 minutes***. Requests to change the 50-minute session will need to be discussed with the therapist in order for time to be scheduled in advance. I understand that during the course of treatment, material may be discussed which can be upsetting, but necessary to help me resolve my problems. Psychotherapy is a cooperative effort between me and my therapist and there is no guarantee that I will feel better.

I understand that conversations with my therapist are strictly confidential, except under certain legally defined situations. Confidentiality may be broken in situations involving threats of self-harm, harm to others and cases of child or elder abuse. I understand that my therapist will make reasonable efforts to resolve these situations before breaking confidentiality. A copy of the ***Limits of Confidentiality form*** is included with your intake packet.

If you need to contact me between sessions, please leave a message on my voicemail. Since I am often not immediately available, I will return your call within 24 business hours. Clients are permitted to send HIPAA complaint text messages to their counselor using the ***SimplePractice telehealth app***. By using the *SimplePractice app*, clients can schedule/cancel appointments as well as send secure text messages to their counselor. Please do not send text messages outside of using the SimplePractice app. If you are experiencing a mental health emergency and it's after hours, please dial the on-call number listed on the voicemail and/or proceed to the nearest emergency room for immediate care.

Social Media: Due to the importance of your confidentiality and the need to minimize dual relationships; *Sycamore Wellness Group clinicians and staff* do not accept friend requests from current or former clients on their personal social networking sites (FaceBook, LinkedIn, etc.). However, if you want to follow *Sycamore Wellness Group* business social networking sites, then please beware of the potential breach of confidentiality and harm it can cause you. People can figure out that you are a client just by becoming a friend or following the business page.

I understand that regular participation will produce maximum benefits; but my participation is strictly "voluntary", and I am free to discontinue treatment at any time. **We ask that you let us know if you are terminating services, so we can complete the appropriate paperwork.**

I understand that I am financially responsible for this treatment (via health insurance, Employee Assistance Program (EAP) benefits or private pay). If clients are using their health insurance or private pay, then all *payments are due the same day services are rendered*. We accept cash, credit/debit cards or checks. There is a $35 fee for any returned checks.

We reserve the right to pursue the collection of any and all unpaid balances using a collection agency or filing with the county small claims court.

If you are using your health insurance or EAP benefits and are terminated or resigning from your place of employment, you must let Sycamore Wellness Group, LLC know immediately. Services may be interrupted unless you are able to pay for services using your health insurance or private pay.

- **LATE CANCELLATIONS (LESS THAN A 24-HOUR NOTICE) WILL BE CHARGED A FEE OF $35**

- **ALL NO-SHOW APPOINTMENTS WILL BE SUBJECT TO A FULL CHARGE OF THE SESSION FEE**

- **IN-PERSON APPOINTMENTS:** Please bring this form and other assessment forms to your first appointment.

- **VIRTUAL APPOINTMENTS:** Please make sure you complete and submit all intake forms and assessment forms via SimplePractice client portal. An email with all documents will be sent to you prior to your appointment.

- **MEDICAL RECORD STORAGE**: All medical health records will be kept confidential in a locked file cabinet and/or the SimplePractice electronic health record software.

- **DESTRUCTION OF MEDICAL RECORDS**: Medical health records will be destroyed by cross-cut shredding or by deleting medical health records from SimplePractice electronic health record software after seven years from discharge date.

I have read and understand the conditions stated above and I consent to voluntarily participate in treatment.

- **I have been given a brochure containing**:

    - Notice of Privacy Practices for my *Health Care Information* and *Use of Sycamore Wellness Group Website*.
    - Limits of Confidentiality Guidelines
    - Client Rights and Responsibilities

_____	_____
Clients Signature	Date
_____	_____
Clients Partner/Spouse or Family Members Signature	Date
_____	_____
Jamie Cross-Lee, PhD, LPC	Date

8046 Roswell Road, Suite 102, Sandy Springs, GA 30350
(phone) 770-557-1520 404-537-1947 (fax)
www.sycamorewellnessgroup.com