Cornerstone Clinic *Medical & Counseling Center*

Counseling Intake Form

Client Name: ____
First MI Last

Mailing Address: ____

____

Res. Address: ____

____

To respect your privacy, we need a confidential phone number: ____________________

Work Phone:____________ Home Phone:__________ Cell:______________

SSN: ________________ Birthdate: ____________________

Gender: ❍ Male ❍ Female Employer: ______________________________

How did you hear about us?______________________________________

Emergency Contact: ____

Family History

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

Were there any adoptions in your family? Explain:______________________

Marital Status ❍ Single ❍ Engaged ❍ Married ❍ Separated ❍ Divorced
❍ Single w/ Children ❍ Married with Children ❍ Widowed

Are you living with your spouse/partner? ❍ Yes ❍ No

Ages of your children: ____ ____ ____ ____ ____ ____ ____

Religious Preference:____

Cultural Background:____

Insurance Information

Insurance Co.:________________ Address: ______________________________

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800 #: ________________ Your ID#:______________________________

Group ID#: ________________ Other Info:____________________________

In order to process your insurance claims more efficiently, we need a copy of your insurance card.
Please gie to front desk receptionist for copying.

To the best of my knowledge, this information is true.

Signature: ____________________ Date: ______________________

Counseling Intake Questionnaire

Counseling/Medical History

Have you previously sought counseling? ✶ Yes ✶ No

If yes, please explain____

____

Medical History____

____

Current Health Status ✶ Excellent ✶ Good ✶ Fair ✶ Poor

How long has it been since your last physical exam?________________________

Current Medications____

Chemical Use

History: ✶ Yes ✶ No Current: ✶ Yes ✶ No

Substances____

Frequency____

Amount____

Longest period of sobriety__________________ Length of use________________________

Prior Treatment____

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Rate the items with which you are currently having problems.
Circle the number that best indicates the existence or 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

continued on next page

Counseling Intake Questionnaire

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

Have you ever felt people were watching you?	✶ Yes	✶ No
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 attempted suicide?	✶ Yes	✶ No

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

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(Use the back of this page if necessary.)

Information and Informed Consent

(Please initial on line indicating you read the paragraph)

_____ Introduction
Cornerstone Clinic is committed to treating you as a whole person, body, soul and spirit. We provide counseling services to help nurture you to become a healthier individual in all three of these areas. Our trained professionals are skilled in pastoral and clinical counseling and are here to serve you. Thank you for coming to Cornerstone Clinic!

_____ Confidentiality
We place a high value on confidentiality and we will make every effort to ensure that your information will be kept confidential. Because we endeavor to be the best we can, we occasionally bring client cases to case consultation. Should we discuss your case, we will not mention your name. You should be aware however, that legal requirements specify certain conditions in which it is necessary for us to disclose your name and/or your treatment. These requirements are:

1. If we believe you are a danger to yourself or others.
2. If we become aware of any involvement you have in the abuse of children, elderly, or disabled persons.
3. If we are ordered by a judge or court to release your records.

_____ Fees
The current fee for receiving counseling at Cornerstone Clinic is $125 for the first fifty-minute intake/diagnostic interview, and $110 per fifty minute session for each follow-up visit. These fees are due at the time of your visit. These fees also apply to the preparation of assessment reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. If you have insurance, we will bill your primary carrier as a courtesy. **However, if insurance does not pay, you are responsible for your bill.** Fees can be arranged based on review of a financial disclosure form; for further information, inquire at the front desk. At times, we also participate in the training of graduate students who may intern here. Fees for services with interns are different from our hourly rate and the front desk receptionist will explain the fees to you.

_____ Client Responsibility
If, for some reason, you cannot attend a scheduled session, please give us 24-hour notice of cancellation. There will be a thirty dollar ($30) charge for the first missed appointment with failure to either cancel within 24 hours or show for a scheduled appointment. The full fee of $110 will be charged for second and subsequent missed sessions. Consistent failure to cancel within 24 hours, not show for an appointment or to keep account(s) current may result in termination or referral. Please be as committed to us as we are to you.

_____ **Consent is hereby given CHA/Cornerstone Clinic to administer treatment deemed necessary. I also consent to the release of information for insurance purposes from my insurance company to Cornerstone Clinic. This signed consent shall remain in effect until it is revoked by patient or guardian, at which time written notice must be given to withdraw existing consent.**

I am responsible for all charges generated for services rendered, including services not covered by my insurance company.

I have read this document and agree to participate in my treatment under the conditions described above.

Signature ____ Date ____________________________