Hope Center Counseling
10274-A Hwy 104
Fairhope, AL 36532

Today's Date:_____

Name: _____
First MI Last

Address:_____City:_____Zip Code:_____

Phone Number: _____Alt:_____

Date of Birth: _____

Marital Status: Single Married Divorced Widowed

Next of Kin/Emergency Contact: _____
Phone Number of Contact: _____Relationship: _____

Church Affiliation: _____City:_____

If client is under 18:
Name of Responsible Party: _____
Phone Number of Responsible Party: _____

ALLERGIES:_____

MEDICATIONS YOU ARE CURRENTLY ON, STRENGTH AND FREQUENCY:

_____
_____
_____
_____
_____

If any/all of the above information changes at any time, it is up to the client or client's parents/guardian (if under 18 years old) to notify the Hope Center of any changes.
Signature: _____Date: _____

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HIPPA NOTIFICATION

I have read the Notice of Privacy Policy located in the lobby of the Hope Center.

Signature _____Date_____

*If you would like a copy of the Privacy Policy please notify the receptionist.

LIMIT OF SERVICE

Hope Center Counseling does NOT seek to represent itself as a full-service, mental health, facility. Counseling services are provided by appointment ONLY. We DO NOT provide an after hours emergency phone number for life-threatening emergencies. If a client feels that they are in danger of harming themselves or others, they will be instructed to call 911 or to proceed to the nearest hospital emergency room.

_____ I understand the Limit of Service the Hope Center presents.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another part without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social serve and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Court Order.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature_____Date_____

*Client's Parent/Guardian if under 18.

MISSED APPOINTMENT POLICY

Hope Center Counseling has a strict policy that requires a 24hour advance notice to cancel or reschedule an appointment. If you do not give a 24hour notice you will be charged $25.00.

_____ I understand the Missed Appointment Policy.

CLIENT REPORT OF PROBLEM

Name _____ **Today's Date** _____ **Case #** _____

Briefly describe your reason(s) for seeking help

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

Outpatient treatment ☐ yes ☐ no
Did it help ☐ yes ☐ no

Therapist's name _____
Dates in treatment _____

Inpatient treatment ☐ yes ☐ no

Where _____

When _____

How long _____

Family history of emotional problems ☐ yes ☐ no

Who _____

Relationship to you _____

Check any of the following items that apply to you: If you have questions you can skip and discuss in session.

- ☐ Thoughts of suicide
- ☐ Trouble getting to sleep
- ☐ Waking during the night
- ☐ Waking early every day
- ☐ Financial problems
- ☐ Loss of appetite
- ☐ Hearing voices
- ☐ Problems at work
- ☐ Trouble concentrating
- ☐ Racing thoughts
- ☐ Legal problems
- ☐ Thoughts of harming others
- ☐ History of attempts to kill yourself
- ☐ Hurting yourself
- ☐ Feelings of hopelessness
- ☐ Inability to make decisions
- ☐ Trouble controlling your temper
- ☐ Large weight gain or loss
- ☐ Seeing things others don't
- ☐ History of physical abuse
- ☐ Phobias
- ☐ Panic attacks
- ☐ Excessive guilt
- ☐ Forgetfulness
- ☐ Mood swings
- ☐ Health problems
- ☐ Family problems
- ☐ Violence toward others
- ☐ Tingling or numbness
- ☐ Depressed mood

Health Status

List any medical problems or physical problems and when they were diagnosed

List any major (where you were put to sleep) surgeries you have had to date

List any serious illness or injuries especially anything involving the head

List *any* allergies to foods or drug

Date of last physical examination _____ Doctor's name _____

May we contact your doctor? ☐ yes ☐ no

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

Check substances you use in any amount at all	Age first used	How much do you use per Weekday	Weekend	Month	Last used
☐ Beer					
☐ Liquor					
☐ Wine					
☐ Marijuana					
☐ Cocaine/Crack					
☐ Methamphetamine/Crystal					
☐ Heroin					
☐ Barbiturates (downers)					
☐ PCP, LSD (Hallucinogens)					
☐ Tobacco (in any form)					
☐ Other _____					

To be completed by adults (18 yrs and older)

Have you ever felt like you should cut down on your drug or alcohol use? ☐ yes ☐ no
Has a friend or relative expressed concerns about your use? ☐ yes ☐ no
Have you ever felt guilty about your drinking or drug use? ☐ yes ☐ no
Have you ever had to take a drink or use a drug the next day to steady your nerves? ☐ yes ☐ no
Are you a recovering alcoholic or a recovering drug addict? ☐ yes ☐ no
Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

To be completed by adolescents (12 yrs to 17 yrs)

Have you ever used alcohol or drugs before or during school? ☐ yes ☐ no
Have you ever missed school (or been truant) because of use or just to use? ☐ yes ☐ no
Have you ever avoided non-users? ☐ yes ☐ no
How often do you get drunk/high? _____
About how often do you use more than one drug when you get high? _____
Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

Therapist _____ Date _____

Client signature _____ Date _____