Empowerment Counseling & Psychotherapy Center
Mental Health Services for Children, Adolescents, Adults and Families
www.EmpowermentCPC.com • (866) 754-4973

NEW CLIENT INTAKE FORM

Welcome to Empowerment CPC! Thank you for taking a few minutes to fill out this form. Please bring this completed form to your first session. The information you provide is protected and confidential.

Today's Date _____

DEMOGRAPHIC INFORMATION

Name _____ Age _____ Date of Birth _____
(First) (Last)

Name of parent/guardian (if under 18 years old):

Name _____ Age _____ Date of Birth _____
(First) (Last)

Address _____
street city state zip

Phone (H) _____ (C) _____ (W) _____

May we leave a message: (**H**) ☐ Yes ☐ No (**C**) ☐ Yes ☐ No (**W**) ☐ Yes ☐ No

Email (please print clearly): _____

Race / Ethnicity: _____ Where did you grow up? _____

Social Security # _____

Insurance Carrier: _____ Insurance #: _____

Who referred you to ECPC? _____

Name of you primary care Physician & phone number: _____

(If referred by your PCP may we send a note stating you have come to see us? ☐ Yes ☐ No)

Whom may we contact in an emergency?: _____

Relationship: _____ Phone: _____

SOCIAL HISTORY

Employer / (School): _____

Years of education completed / degree: _____ Occupation / (Grade): _____

Marital status:

☐ Single / Never Married ☐ Engaged (how long? _____) ☐ Married (how long? _____)

☐ Domestic Partnership (how long? _____) ☐ Committed relationship (how long? _____)

☐ Separated (how long? _____) ☐ Divorced (how long? _____) ☐ Widowed (how long? _____)

Spouse/partner's Name (if applicable) _____ Age _____ Occupation _____

What is your religious background / involvement _____

Who resides with you?

Name	Birth Date	Relationship

I would describe my friendships as: ☐ Close ☐ Somewhat close ☐ Distant ☐ Conflicted

I would describe my relationship with my mother as: ☐ Close ☐ Somewhat close ☐ Distant ☐ Conflicted

I would describe my relationship with my father as: ☐ Close ☐ Somewhat close ☐ Distant ☐ Conflicted

How many siblings do you have? _____ How would you describe your relationship? _____

Which of the following are important supports for you and/or your family?

☐ Extended family ☐ Religion ☐ Friends ☐ Work ☐ Community organizations

What do you do for recreation / fun? _____

PSYCHOLOGICAL & MEDICAL HISTORY:

Have you participated in therapy before?: ☐ Yes ☐ No If yes, when? _____

Name of previous therapist & length of treatment: _____

Reason _____

Are you, currently taking any psychotropic medications? ☐ Yes ☐ No

Name of prescriber? _____

Medications and dosage: _____

Are you, currently taking any other medications? ☐ Yes ☐ No

Name of prescriber? _____

Medications and dosage: _____

How would you characterize your current medical health? _____

Have you had any major health problems? ☐ Yes ☐ No (If yes please explain): _____

When was your last medical check-up / physical? _____

To your knowledge were the results normal? ☐ Yes ☐ No (If no please explain): _____

_____

Do you have any allergies (environmental, food, medication, seasonal)? ☐ Yes ☐ No (If yes please explain, include adverse reactions): _____

_____

_____

Have you ever been hospitalized for a medical illness, injury or surgery? ☐ Yes ☐ No.
If yes, please explain: _____

_____

_____

Have you ever been hospitalized for a mental or emotional illness? ☐ Yes ☐ No.
If yes, please explain—dates, where, reason: _____

_____

_____

Has anyone in your family ever been hospitalized for mental or emotional illness? ☐ Yes ☐ No
If yes, please explain—dates, where, reason: _____

_____

_____

Substance abuse / addiction history? ☐ Yes ☐ No (please explain) _____

_____

Substance Use: In the past 2 weeks I have used:

_____	Caffeine	Amount per day: _____
_____	Cigarettes	Amount per day: _____
_____	Alcohol	Amount per day: _____
_____	OTC medications	Amount/type per day: _____
_____	Recreational drugs	Amount/type per day: _____

Legal History (arrests, prison, DWI, parking tickets?) _____

_____

FAMILY HEALTH HISTORY:

Which of the following health problems are present in your family?

☐ Attention-Deficit/Hyperactivity: Family Member (s): _____

☐ Anxiety: Family Member (s): _____

☐ Autism: Family Member (s): _____

☐ Bipolar: Family Member (s): _____

☐ Depression: Family Member (s): _____

☐ Diabetes: Family Member (s): _____

☐ Heart disease: Family Member (s): _____

☐ High blood cholesterol: Family Member (s): _____

☐ Insomnia: Family Member (s): _____

☐ Intellectual Disability: Family Member (s): _____

☐ Learning disability: Family Member (s): _____

☐ Obesity: Family Member (s): _____

☐ Posttraumatic Stress Disorder: Family Member (s): _____

☐ Schizophrenia: Family Member (s): _____

☐ Seizures: Family Member (s): _____

☐ Substance abuse: Family Member (s): _____

☐ Sudden death from heart attack before age 50: Family Member (s): _____

☐ Suicide: Family Member (s): _____

☐ Tics/Tourettes: Family Member (s): _____

☐ None of the above: Family Member (s): _____

☐ Family history unknown ☐ Adopted ☐ Foster Care

PRESENTING PROBLEM:

What brings you here today? _____

_____

_____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___marriage	___divorce/separation	___alcohol/drugs	___God/faith
___pre-marital	___child custody	___other addictions	___church/ministry
___being single	___disabled	___grief/loss	___past hurts
___sexual issues	___work/career	___depression	___codependency
___family	___school/learning	___fear/anxiety	___intimacy
___children	___money/budgeting	___anger control	___communication
___parents	___aging/dependency	___loneliness	___self-esteem
___in-laws	___weight control	___mood swings	___stress control

Crisis Information:

Are you having any current suicidal thoughts, feelings or actions? ☐ Yes ☐ No

If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? ☐ Yes ☐ No

If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assaultive behavior? ☐ Yes ☐ No

If yes, describe _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? ☐ Yes ☐ No

If yes, describe _____

THANK YOU for taking the time to fill out this information sheet.

Empowering you to be who you were designed to be.

Empowerment Counseling & Psychotherapy Center
Mental Health Services for Children, Adolescents, Adults and Families
www.EmpowermentCPC.com • (866) 754-4973

Statement of Patient/Client Rights & Responsibilities

• Patients/Clients have the right to be treated with dignity and respect.
• Patients/Clients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
• Patients/Clients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
• Patients/Clients have the right to access care easily and in a timely fashion.
• Patients/Clients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
• Patients/Clients have the right to share in developing their plan of care.
• Patients/Clients have the right to the delivery of services in a culturally competent manner.
• Patients/Clients have the right to information about the organization, its providers, services, and role in the treatment process.
• Patients/Clients have the right to information about provider work history and training.
• Patients/Clients have the right to information about clinical guidelines used in providing and managing their care.
• Patients/Clients have a right to know about advocacy and community groups and prevention services.
• Patients/Clients have a right to freely file a complaint, grievance, or appeal, and to learn how to do so.
• Patients/Clients have the right to know about laws that relate to their rights and responsibilities.
• Patients/Clients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

• Patients/Clients have the responsibility to treat those giving them care with dignity and respect.
• Patients/Clients have the responsibility to give providers the information they need, in order to provide the best possible care.
• Patients/Clients have the responsibility to ask their providers questions about their care.
• Patients/Clients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
• Patients/Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
• Patients/Clients have the responsibility to tell their provider about medication changes, including medications given to them by others.
• Patients/Clients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
• Patients/Clients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
• Patients/Clients have the responsibility to let their provider know about problems with paying fees.
• Patients/Clients have the responsibility not to take actions that could harm others.
• Patients/Clients have the responsibility to report fraud and abuse.
• Patients/Clients have the responsibility to openly report concerns about quality of care.
• Patients/Clients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc).
• Patients/Clients have the right and the responsibility to understand and help develop plans and goals to improve their health. I have read and understood my rights and responsibilities.

Empowerment Counseling & Psychotherapy Center
Mental Health Services for Children, Adolescents, Adults and Families
www.EmpowermentCPC.com • (866) 754-4973

LIMITS OF CONFIDENTIATLITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party 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 of 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 in 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 service 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 client's records.

Insurance Providers (when applicable)
Insurance companies and other third party payers are given information that they request regarding services to clients.

Information that may be requested includes but is not limited to types of service, dates/times of service, diagnosis treatment plan, description of impairment, progress of therapy, case notes and summaries.

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

SIGN HERE

_____
Client Signature (Client's Parent/Guardian under 18)

_____
Today's Date

Empowerment Counseling & Psychotherapy Center
Mental Health Services for Children, Adolescents, Adults and Families
www.EmpowermentCPC.com • (866) 754-4973

CANCELLATION POLICY & AUTHORIZATION TO CHARGE CREDIT CARD

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with **less** than a 24-hour notice unless it is due to illness or an emergency. We require a credit card on file to charge in these instances. Please provide your credit card information below.

Name on credit card: _____

Credit Card #: _____

Type of Card: ☐ Visa ☐ MC ☐ Amex ☐ Discover

Expiration date: _____ CVV: _____

Thank you for your consideration regarding this important matter.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

Empowerment Counseling & Psychotherapy Center
Mental Health Services for Children, Adolescents, Adults and Families
www.EmpowermentCPC.com • (866) 754-4973

Signature Page

Print Name: _____

By signing this, I acknowledge receipt and understanding of the information regarding my rights and responsibilities.

_____ **Date:** _____

Signature

By signing this, I acknowledge receipt and understanding of the limits of confidentiality and understand the meanings and potential ramifications.

_____ **Date:** _____

Signature

By signing this, I acknowledge and understand the cancellation policy and the responsibility of providing 24 hours notice for a cancellation of a therapy session. If I do not provide a minimum of 24 hours notice I may be charged for the missed session and/or be placed on a treatment contract.

_____ **Date:** _____

Signature

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns	0	+ 0	+ 0	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: 0

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

MOOD AND FEELINGS QUESTIONNAIRE: Long Version

This form is about how you might have been feeling or acting **recently**.

For each question, please check (✓) how you have been feeling or acting ***in the past two weeks***.

If a sentence was not true about you, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about you most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	**NOT TRUE**	**SOME TIMES**	**TRUE**
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I was less hungry than usual.			
4. I ate more than usual.			
5. I felt so tired I just sat around and did nothing.			
6. I was moving and walking more slowly than usual.			
7. I was very restless.			
8. I felt I was no good anymore.			
9. I blamed myself for things that weren't my fault.			
10. It was hard for me to make up my mind.			
11. I felt grumpy and cross with other people.			
12. I felt like talking less than usual.			
13. I was talking more slowly than usual.			
14. I cried a lot.			

15. I thought there was nothing good for me in the future.			
16. I thought that life wasn't worth living.			
17. I thought about death or dying.			
18. I thought my family would be better off without me.			
19. I thought about killing myself.			
20. I didn't want to see my friends.			
21. I found it hard to think properly or concentrate.			
22. I thought bad things would happen to me.			
23. I hated myself.			
24. I felt I was a bad person.			
25. I thought I looked ugly.			
26. I worried about aches and pains.			
27. I felt lonely.			
28. I thought nobody really loved me.			
29. I didn't have any fun in any of my activities.			
30. I thought I could never be as good as other people.			
31. I did everything wrong.			
32. I didn't sleep as well as I usually sleep.			
33. I slept a lot more than usual.			

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	0 +	0 +	0 +	0
Total Score *(add your column scores)* =				0

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.

Please save and email completed document to our secure email
Intake@empowermentcpc.com

SUBMIT