Alpha Hope Counseling, Inc.

Dawsonville
137 Prominence Ct, Suite 220
Dawsonville, GA 30534
706-216-4735
Fax: 706-216-7909

Cumming
327 Dahlonega St., Suite 302B
Cumming, GA 30040
678-571-7505
Fax: 770-886-7148

Confidential Client Counseling Intake

Name: _____ Date: _____

Home Address: _____ DOB: _____/ _____/ _____

City, State, Zip: _____ SS#: _____ - _____ - _____

Home Phone: (_____) _____ - _____ Sex: Male ❑ Female ❑

Cell Phone: (_____) _____ - _____ Email: _____

Employer: _____ Work Phone: (_____) _____ -_____

May we call you at: Home: Yes ❑ No ❑ Work: Yes ❑ No ❑ Cell: Yes ❑ No ❑
May we send mail to you at your home address? Yes ❑ No ❑
Marital Status: Never Married ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

Spouse's Name: _____ DOB _____/ _____/ _____

Children's Names: _____ DOB _____/ _____/ _____

_____ DOB _____/ _____/ _____

_____ DOB _____/ _____/ _____

Previous Marriage: Yes ❑ No ❑
Name of Previous Spouse: _____ How Long? _____

Highest Level of Education: _____ Spouse's _____

Have you ever been in counseling before? Yes ❑ No ❑ If yes, please provide counselor name and location, dates and reason for counseling: _____

_____

What concerns are you seeking counseling for today? _____

Emergency Contact

Who should we contact in case of an emergency?

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address:_____ City, State, Zip: _____

Health & Personal Information

Would you describe your current physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑
Would you describe your current diet as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

How many hours do you sleep each night? _____

Do you currently have any physical problems? Yes ❑ No ❑ If yes, please explain: _____

_____

Please list any medical conditions or any disabilities: _____

_____

Please list all prescription and OTC medications currently being taken:

Medication	Dosage	Physician	Purpose

Have you ever taken illegal drugs? Yes ❑ No ❑

Do you drink alcoholic beverages Yes ❑ No ❑ How many per day? _____ per week? _____

Are religious or spiritual issues important to you? Yes ❑ No ❑
How much do they impact/influence your daily life? A great deal ❑ A reasonable amount ❑ Some ❑ Very little ❑
Do you currently attend church? Yes ❑ No ❑

If yes, where do you attend? _____

How did you hear about Alpha Hope Counseling? _____

Please indicate your current level of the following symptoms or behaviors:

	Never	Rarely	Sometimes	Frequently
Feeling angry or having outbursts:	❑	❑	❑	❑
Inability to control my thoughts:	❑	❑	❑	❑
No one cares about me:	❑	❑	❑	❑
Loss of, or increased appetite:	❑	❑	❑	❑
Feeling distant from God:	❑	❑	❑	❑
Trouble controlling worry or anxiety:	❑	❑	❑	❑
Life is hopeless:	❑	❑	❑	❑
Concerns with emotional stability:	❑	❑	❑	❑
Withdrawing from relationships:	❑	❑	❑	❑
Excessive use of alcohol or drugs:	❑	❑	❑	❑
Trouble concentrating:	❑	❑	❑	❑

Loss of sexual interest:	❑	❑	❑	❑

	Never	**Rarely**	**Sometimes**	**Frequently**
I am lonely:	❑	❑	❑	❑
Feelings of depression:	❑	❑	❑	❑
Easily distracted:	❑	❑	❑	❑
People are out to get me:	❑	❑	❑	❑
Wanting to sleep all the time:	❑	❑	❑	❑
Nightmares:	❑	❑	❑	❑
Often fatigued:	❑	❑	❑	❑
Avoiding people:	❑	❑	❑	❑
Afraid of specific places or things:	❑	❑	❑	❑
Excessive recurring thoughts:	❑	❑	❑	❑
Lack of interest/motivation in activities:	❑	❑	❑	❑
Getting into trouble at school/work:	❑	❑	❑	❑
Having little self-confidence:	❑	❑	❑	❑
I do not deserve to be forgiven:	❑	❑	❑	❑
Feeling numb, having no emotions:	❑	❑	❑	❑
Out of control:	❑	❑	❑	❑
Afraid of being alone:	❑	❑	❑	❑
Insomnia:	❑	❑	❑	❑
Irritability:	❑	❑	❑	❑
I hear voices:	❑	❑	❑	❑
Feeling of being disoriented:	❑	❑	❑	❑
Why do I feel so different?	❑	❑	❑	❑
Most people do not like me:	❑	❑	❑	❑
Obsession with certain activities:	❑	❑	❑	❑
Feeling of stress, under too much pressure:	❑	❑	❑	❑
I want to hurt someone:	❑	❑	❑	❑
I cannot do anything right:	❑	❑	❑	❑
Mood shifts:	❑	❑	❑	❑
Trouble making or keeping friends:	❑	❑	❑	❑
Feeling fat:	❑	❑	❑	❑
People manipulate or control me:	❑	❑	❑	❑
I am often physically sick:	❑	❑	❑	❑

Cancellation Policy

If you are unable to attend a session, please cancel within 24 hours. Appointments not cancelled within 24 hours will be charged a $45.00 missed appointment fee.

Payment Information

We accept payment in cash, check and credit or debit cards. A $25.00 fee is charged for returned checks. Payment or insurance co-pay is due at time of service. Insurance is not accepted for court required assessments and groups.

Insurance Information

We accept most insurance plans and will be glad to assist you in filing your insurance. We are not, however, allowed to participate in Medicare or accept assignment of Medicare benefits.

Policy Holder	S.S. Number

Insurance Company	Employer	Date of Birth

Policy Number	Group Number	Date of Coverage

Employer Assistance Program _____
Provide name

Authorization #	Number of visits

- I understand that I am responsible for any fees not paid by my insurance company within 30 Days.
- I authorize the release of any medical information necessary to process this claim. When applicable, I also request payment of government benefits either to myself or to the party who accepts assignment
- I authorize payment of medical benefits to the Physician or Supplier for services rendered.

Patient Signature	**Date**	**Parent/Guardian Signature**	**Date**