

Atlanta Counseling Center

6111-C Peachtree-Dunwoody Rd Atlanta, Georgia 30328

Telephone (770) 396-0232 - Fax (770) 399-0007

Therapist _____ Date _____

Patient Name _____

M/F _____ Birth Date _____ SS# _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ May we contact you at work? Yes/No
(C) _____

Name of Person Responsible for Payment _____

Address (if different from above) _____

City _____ State _____ Zip _____ Phone # _____

Do you have insurance to cover Mental Health Services? Yes _____ No _____

Insurance Company _____ Medicare _____ Medicaid _____

Do you belong to a Managed Care Plan? Yes _____ No _____

Which Company _____

If your clinician is a provider with the following insurance carriers we will file your claim:

Blue Cross Blue Shield of GA
Medicaid
Medicare
Principal

United Healthcare PPO
Cigna PPO
Magellan
Humana PPO

If you are with one of the above companies please provide your insurance card to be photocopied for our files. Due to complex insurance programs, it is the patient's responsibility to verify coverage and obtain authorization. Sign below to signify your consent for each session to be filed with your insurance carrier, if applicable.

Regardless of insurance coverage, if your account has a balance you are personally responsible for timely payment. Statements will be mailed to your home on a monthly basis.

Signature

Date

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Intake Questionnaire

To facilitate your initial visit, please provide the following information. This information will be read by your doctor or therapist, and will become part of your **CONFIDENTIAL** record. You may use the back of any page, if desired.

Date _____

Name _____
Last First MI

SS# _____ Birthdate _____ Age _____

Telephone Home # _____ Work # _____ Cell # _____

Address _____

City _____ State _____ Zip Code _____ County _____

How long at this address? _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Education _____ Employer _____

Address _____ How long? _____

Occupation _____

Where would you prefer our office to contact you?

May we call you at home? Yes _____ No _____

At work? Yes _____ No _____ By cell phone? Yes _____ No _____

Partner / Spouse _____ Age _____

Name

Education _____ Employer _____ Work # _____

Partner's address (if different) _____ City _____

State _____ Zip _____

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Military Service (include dates) _____

Children / Household Members

_____ Age _____ Relationship _____
Name

_____ Age _____ Relationship _____
Name

_____ Age _____ Relationship _____
Name

_____ Age _____ Relationship _____
Name

Nearest Relative (not living with you) _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Emergency Contact # _____ Name _____

Relationship _____ Telephone # _____

Physician _____ Telephone # _____

Date of last physical _____

List any medications (including over-the-counter medicines) you take

List any allergies or adverse reactions to any medications.

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Describe any current or past physical problems you have:

Describe any current or past physical problems members of your household have:

How significant is your religion/spirituality to your everyday life? _____

Have you ever received counseling before? _____

When _____

Reason _____

Reason you are seeking counseling at this time:

How did you hear about us?

Yellow Pages ____ Friend/Relative ____ Church ____ Doctor ____ Internet ____

Other _____

Name of Person who referred you to us: _____

May we thank them for referring you? Yes ____ No ____ Phone # _____

Address _____ City _____ State _____

Zip _____

Signature _____ Date _____

The following is a list of common problems. Read each one carefully and circle the number to the right that best describes how much that problem is of concern to you.

0 – Not at all	1 – Mildly	2 – Moderately	3 – Very much	4 – Extremely	
1. Feeling low in energy or slowed down.	0	1	2	3	4
2. Dissatisfied with my spiritual life.	0	1	2	3	4
3. Repeated, unwanted thoughts that won't leave my mind.	0	1	2	3	4
4. Loss of control, or fear of losing control of my temper.	0	1	2	3	4
5. Not satisfied with my weight.	0	1	2	3	4
6. Nervousness or shakiness inside.	0	1	2	3	4
7. Troubled by sexual thoughts or behavior.	0	1	2	3	4
8. Drink when troubled or under pressure.	0	1	2	3	4
9. Unusual fears that most people don't have.	0	1	2	3	4
10. Thoughts of ending my life.	0	1	2	3	4
11. Sleep that is restless or disturbed.	0	1	2	3	4
12. Problems with police or legal matters.	0	1	2	3	4
13. Feel withdrawn and/or isolated.	0	1	2	3	4
14. Loss/absence of sexual desire or pleasure.	0	1	2	3	4
15. Other people being aware of my private thoughts.	0	1	2	3	4
16. Feeling hopeless about the future.	0	1	2	3	4
17. Problems with my eating.	0	1	2	3	4
18. Spells of terror or panic.	0	1	2	3	4
19. Feeling shy or uneasy with the opposite sex / same sex.	0	1	2	3	4
20. Drinking or emotional problems in my or my parent's family.	0	1	2	3	4

21. Feeling that I am watched or talked about by others.	0	1	2	3	4
22. Things about my life are too painful to talk about.	0	1	2	3	4
23. Difficulty feeling close to another person.	0	1	2	3	4