NEW HOPE
COUNSELING

INTAKE FORM (ADULT)

Date: _____

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ Gender: Male ____ Female ____

Address: _____ City: _____ State: _____ Zip Code: _____

Home phone:(____)_____ Cell:(____) _____ Work phone:(____)_____

Email Address: _____

Marital Status: Single ___ Married ___ Other ___

Emergency Contact Name: _____ Relationship: _____ Phone #: (___) _____

How did you hear about New Hope Counseling?

Redeemer Presbyterian Church ____	Fountain Square Presbyterian Church ____	Midtown ____
SOMA ___	Christ Community ____	Referred by friend ____
Campus Outreach _____	Online search ____	Other *(please specify)* _____

Insurance information: *Note: New Hope Counseling does not currently accept insurance. This section can be left blank.*

Employer: _____ Insurance Carrier: _____

Responsible Party: _____

Primary Insured's Name (if different than above): _____ Primary Insured's Date of Birth: _____

Primary Insured's Address: _____

Primary Insured's Phone: (___)_____

NOTE: If insurance is to be filed, all standard billing rates must apply. New Hope Counseling will file insurance claims on client's behalf.

Payment information:

PLEASE INITIAL _____ New Hope Counseling may electronically store my credit card information.

PLEASE INITIAL _____ New Hope Counseling may automatically charge my credit card for appointments and/or for no show/late cancellation charges.

Health information:

Date of last physician visit: _____ What was the purpose of this visit? _____

Please list any medications you are currently taking:

Medication	Dosage/frequency	Results

Please list any previous therapy or treatment you have received from mental health professionals:

Date(s)	Counselor name / place of therapy	Nature of problem / reason for seeking therapy	Result of treatment

Over the last 2 weeks, how often have you been bothered by the following?	Not at all	Some Days	More than half the days	Most 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 asleep, 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 let your family down	0	1	2	3
7. Trouble concentrating on things like reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking slowly that people have noticed	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Column Totals Questions 1 – 9 _____
Column Totals Questions 10 – 16 _____

Based on the above challenges, 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? *Please circle one:*

Not difficult at all Somewhat difficult Very difficult Extremely difficult