



Dear EMERGE Client,

Thank you for entrusting EMERGE Counseling Services to assist with your concerns. Our team of clinical and administrative professionals desire to provide you with the highest quality Christian mental health services.

To help us best serve you, please thoroughly review and complete the attached documents and be sure to note any questions you have about the contents. Thank you for completing these documents prior to your first appointment.

**PLEASE NOTE:** For Minor Clients (under the age of 18), a Parent/Legal Guardian is required to accompany their child and remain onsite during the child's first appointment. Please check with the clinician for the need of your ongoing involvement in the therapeutic process in subsequent sessions.

**Current Custody Documents** are required if the client is a minor with divorced parents or if the client is under the care of a guardian or Children's Services. This helps us to appropriately determine consent for care and access to confidential information. Please submit the full document along with the below forms.

**Form A - HISTORY FORM** - Please print one for each individual seen at EMERGE. For minors, you will need to complete the Child/Adolescent version.

**Form B - NOTICE OF PRIVACY PRACTICES** -This brochure outlines important information regarding the privacy of your health information. Please review prior to your first appointment.

**Additional items that are very important to bring to your first appointment:**

- **Insurance cards** for all health plans in which you participate if you plan to access your health insurance benefits.
- **Additional materials** you feel may be helpful to your clinician (e.g. reports, test results from schools, medical and/or mental health professionals, legal documents).
- **Your treatment goals.** How can we best serve you?
- **Your calendar/mobile device** for scheduling appointments.

Should you need to cancel your session, please contact EMERGE Counseling Services as soon as possible (330-867-5603, option 3) so that we may reschedule you. **A 24 hour notice avoids a late cancellation fee.**

Please know that we desire to be helpful to you and to make your experience at EMERGE Counseling Services as beneficial and pleasant as possible. We always welcome your feedback and look forward to a productive and successful relationship. May God richly bless you!

Client Registration Team  
EMERGE Counseling Services  
330-867-5603 ext 3  
intake@emerge.org



List any abnormal lab test results: Date \_\_\_\_\_ Result \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_

**EMOTIONAL/PSYCHIATRIC HISTORY**

**||| Prior outpatient psychotherapy?**

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment by \_\_\_\_\_ for \_\_\_\_\_ sessions from \_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_  
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**||| Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment at \_\_\_\_\_ from \_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_  
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**||| Has any family member had outpatient psychotherapy? If yes, please circle: Grandparents Parents Siblings Aunt/Uncle Cousins**

No Yes Please Provide Details for any circled: \_\_\_\_\_

**||| Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, please circle: Grandparents Parents Siblings Aunt/Uncle Cousins**

No Yes Please Provide details for any circled: \_\_\_\_\_

**||| Has any family member used psychotropic medications? If yes, please circle: Grandparents Parents Siblings Aunt/Uncle Cousins**

No Yes Please Provide details for any circled: \_\_\_\_\_

**SUBSTANCE USE HISTORY (check all that apply for patient)**

Substance use status:	Substances used: (complete all that apply)	Current Use	First use age	Last use age	Frequency	Amount	Family History*
<input type="checkbox"/> no history of abuse	<input type="checkbox"/> alcohol	Yes/No	_____	_____	_____	_____	Yes/No
<input type="checkbox"/> active abuse	<input type="checkbox"/> amphetamines/speed	Yes/No	_____	_____	_____	_____	Yes/No
<input type="checkbox"/> early full remission	<input type="checkbox"/> barbiturates/downers	Yes/No	_____	_____	_____	_____	Yes/No
<input type="checkbox"/> early partial remission	<input type="checkbox"/> caffeine	Yes/No	_____	_____	_____	_____	Yes/No
<input type="checkbox"/> sustained full remission	<input type="checkbox"/> cocaine/crack cocaine	Yes/No	_____	_____	_____	_____	Yes/No
<input type="checkbox"/> sustained partial remission	<input type="checkbox"/> heroin	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> hallucinogens (e.g., LSD)	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> inhalants (e.g., glue, gas)	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> marijuana or hashish	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> nicotine/cigarettes/tobacco	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> PCP	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> prescription drug abuse	Yes/No	_____	_____	_____	_____	Yes/No
	<input type="checkbox"/> other	Yes/No	_____	_____	_____	_____	Yes/No

**Consequences of substance abuse for patient (check all that apply):**

- |                                              |                                                         |
|----------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> sleep disturbance              |
| <input type="checkbox"/> binges              | <input type="checkbox"/> seizures                       |
| <input type="checkbox"/> medical conditions  | <input type="checkbox"/> job loss                       |
| <input type="checkbox"/> assaults            | <input type="checkbox"/> tolerance changes              |
| <input type="checkbox"/> blackouts           | <input type="checkbox"/> arrests                        |
| <input type="checkbox"/> suicidal impulse    | <input type="checkbox"/> loss of control of amount used |
| <input type="checkbox"/> overdose            | <input type="checkbox"/> other _____                    |

[ ] relationship conflicts

**FAMILY HISTORY**

**FAMILY OF ORIGIN**

**Present during childhood:**

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

**Parents' current marital status:**

- [ ] married to each other
- [ ] separated for \_\_\_ years
- [ ] divorced for \_\_\_ years
- [ ] mother remarried \_\_\_ times
- [ ] father remarried \_\_\_ times
- [ ] mother involved with someone
- [ ] father involved with someone
- [ ] mother deceased for \_\_\_ years  
your age at mother's death \_\_\_\_\_
- [ ] father deceased for \_\_\_ years  
your age at father's death \_\_\_\_\_

**Describe parents:**

<b>Father</b>	<b>Mother</b>
full name _____	_____
occupation _____	_____
education _____	_____
general health _____	_____

**Describe childhood family experience:**

- [ ] outstanding home environment
- [ ] normal home environment
- [ ] chaotic home environment
- [ ] witnessed physical/verbal/sexual abuse toward others
- [ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: \_\_\_\_\_ Circumstances: \_\_\_\_\_

Special circumstances in childhood: \_\_\_\_\_

**IMMEDIATE FAMILY**

**Marital status:**

- [ ] single, never married
- [ ] engaged \_\_\_ months
- [ ] married for \_\_\_ years
- [ ] divorced for \_\_\_ years
- [ ] separated for \_\_\_ years
- [ ] divorce in process \_\_\_ months
- [ ] live-in for \_\_\_ years
- [ ] \_\_\_ prior marriages (self)
- [ ] \_\_\_ prior marriages (partner)
- [ ] widow(er) for \_\_\_ years

**Intimate relationship:**

- [ ] never been in a serious relationship
- [ ] not currently in relationship
- [ ] currently in a serious relationship

**Relationship satisfaction:**

- [ ] very satisfied with relationship
- [ ] satisfied with relationship
- [ ] somewhat satisfied with relationship
- [ ] dissatisfied with relationship
- [ ] very dissatisfied with relationship

**List all persons currently living in patient's household:**

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List children not living in same household as patient:**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: \_\_\_\_\_

Describe any past or current significant issues in intimate relationships: \_\_\_\_\_

Describe any past or current significant issues in other immediate family relationships: \_\_\_\_\_

**FAMILY HISTORY (check all that apply):**

- |                                                    |                   |                         |                                   |
|----------------------------------------------------|-------------------|-------------------------|-----------------------------------|
| [ ] tuberculosis                                   | [ ] heart disease | [ ] high blood pressure | [ ] behavior problems             |
| [ ] thyroid problems                               | [ ] diabetes      | [ ] cancer              | [ ] Alzheimer's disease/ Dementia |
| [ ] mental retardation                             | [ ] stroke        | [ ] birth defects       |                                   |
| [ ] other chronic or serious health problems _____ |                   |                         |                                   |

\*If Family History of substance abuse was indicated above, please indicate relation (e.g. father, mother, sibling, etc.) \_\_\_\_\_

**SOCIO-ECONOMIC HISTORY** (check all that apply for patient)

**Living situation:**

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

**Social support system:**

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

**Sexual history:**

- heterosexual orientation  currently sexually dissatisfied
  - homosexual orientation  age first sex experience \_\_\_\_\_
  - bisexual orientation  age first pregnancy/fatherhood \_\_\_\_\_
  - currently sexually active  history of promiscuity age \_\_\_ to \_\_\_
  - currently sexually satisfied  history of unsafe sex age \_\_\_ to \_\_\_
- Additional information: \_\_\_\_\_

**Employment:**

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: \_\_\_\_\_

**Military history:**

- never in military
- served in military - no incident
- served in military - with incident

**Cultural/spiritual/recreational history:**

- cultural identity (e.g., ethnicity, religion): \_\_\_\_\_
- describe any cultural issues that contribute to current problem: \_\_\_\_\_
- currently active in community/recreational activities? Yes  No
- formerly active in community/recreational activities? Yes  No
- currently engage in hobbies? Yes  No
- currently participate in spiritual activities? Yes  No
- if answered "yes" to any of above, describe: \_\_\_\_\_

**Financial situation:**

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

**Legal history:**

- no legal problems
  - now on parole/probation
  - arrest(s) not substance-related
  - arrest(s) substance-related
  - court ordered this treatment
  - jail/prison \_\_\_\_\_ time(s)
- total time served: \_\_\_\_\_
- describe last legal difficulty: \_\_\_\_\_

**SOURCES OF DATA PROVIDED ABOVE FOR ALL OR ANY OF CATEGORIES:**

- patient self-report Please initial \_\_\_\_\_
- patient's parent/guardian Please initial \_\_\_\_\_
- other (specify) \_\_\_\_\_