

INTAKE FORM

Please provide the following and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (is under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Marital Status: Never Married Domestic Partnership Married
 Separated Divorced Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (____) _____ May we leave a message? Yes No

Cell/Other Phone:(____) _____ May we leave a message? Yes No

Email: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____



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(229) 226-8800
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Have you previously received any type of mental health services (psychotherapy, psychiatric Services, etc.)?

- No
 Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- No
 Yes, please list: _____

Have you ever been prescribed psychiatric medication?

- No
 Yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercises do you participate in: _____



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4. Please list any difficulties you experience with your appetite or eating patterns.

5. Are you currently experiencing overwhelming sadness, grief or depression?

No

Yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

No

Yes, When did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No

Yes, Please describe? _____

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage in recreational drug use? Daily

Weekly

Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes, for how long? _____

On a scale of 1 - 10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Depression	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Obsessive Compulsive Behavior	Yes No	
Schizophrenia	Yes No	
Suicide Attempts	Yes No	

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious No Yes, please describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?



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LIMITS OF CONFIDENTIALITY

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 or plans 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 suggest 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 clients' records.

INSURANCE PROVIDERS (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that maybe requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of imairment, progress of therapy, case notes, and summaries.

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

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

Date



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CANCELLATION POLICY

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 fee is charged for missed appointments or no show cancellations with less than 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

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

Date



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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
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1. Client's Name: _____
(First) (Middle) (Last)

2. Birth Date: ____/____/____

3. Birth Date: ____/____/____

4. Authorization initiated by: _____
Name (client, provider or other)

5. Information to be Released:

Authorization for Psychotherapy Notes ONLY (**Important:** If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other (describe information in detail): _____

6. Purpose of Disclosure: The reason I am authorizing release is:

My request

Other (describe): _____

7. Person(s) Authorised to Make Disclosure:

8. Person(s) Authorised to Receive Disclosure:

9. This Authorization will expire on ____/____/____ or upon the happening of the following event:

AUTHORIZATION AND SIGNATURE: I authorize the release of my confidential protected health information, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient if Personal Representative: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

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The Following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address:

918 South Broad Street, Thomasville, GA 31792

3. You may refuse to sign this authorization. your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. you need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you **must** receive a copy of the signed authorization.

6. SPECIAL INSTRUCTIONS FOR COMPLETING THIS AUTHORIZATION FOR THE USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES.

HIPAA provides special protection to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the authoer and filed seperate from the rest of theclient’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are seperate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.



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