Covenant Counseling & Family Resource Center

OFFICE USE ONLY			
	Therapist	Date	File #
	Center	Code I C F G	
	Client Fee	Samaritan Subsidy	
	Termination Report Date	Diagnosis Code	

Patient Intake Form

PATIENT INFORMATION

Full Name		What do you prefer to be called?	
Who scheduled the appointment?			
Contact information	Home	Cell	Email
Location preference for messages			
Parent/Guardian (if applicable)			
Mailing Address		City	State / Zip
Date of Birth		Age	❑ Male ❑ Female
Students: School Name/Grade			
Patient's Employer and Occupation		Social Security Number	Phone
Emergency contact		Relationship	Phone
Marital Status S❑ M❑ D❑ W❑ Sep❑ (mark for past and present)		Dates of marriage/ divorce	
Name and birth dates of children: in current relationship		past	

SPOUSE/PARTNER INFORMATION

Full Name		What does he/she prefer to be called?	
Contact information	Home	Cell	Email
Location preference for messages			
Date of Birth		Age	❑ Male ❑ Female
Patient's Employer and Occupation		Social Security Number	Phone
Marital Status S❑ M❑ D❑ W❑ Sep❑ (mark for past and present)		Dates of marriage(s)/ divorce(s)	
Names and birth dates of children from previous relationship(s)			

OTHER INFORMATION (use reverse side if needed)

Others living in household	
Faith affiliation and/or church name (If applicable)	
Referral source	
Reason for coming to therapy	
Prior Treatment- Medical/Psychological	
Current Medications	**Prescribing Physician**
Would you want to be included on the email list for quarterly newsletters and upcoming group/program information?	

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (Print Name) _____, have had full opportunity to read and consider Covenant Counseling & Family Resource Center's **Notice of Privacy Practices** and I understand the content and purpose of this document. By signing this form, I give my consent to this Center to use and disclose my protected health information in the ways listed in the document.

_____ _____
Patient Signature Date

_____ _____
Spouse Signature (if applicable) Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

GEORGIA LAW & CONFIDENTIALITY

With the above understood, communication between you and your therapist is confidential and will not be released to anyone without your authorization. However, there are three exceptions to confidentiality which Georgia law requires counselors to report: 1) when a client appears to be a danger to self or others; 2) when a minor or elder is endangered by abuse or neglect; and 3) when information is lawfully subpoenaed by a court of law. By signing this form, I confirm recognition and understanding of these exceptions.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Spouse Signature (if applicable) Date