Cornelia Williams LLC Intake

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer: DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] Male [ ] Female

SSN: Race: Ethnicity (Hispanic/Latino Origin) [ ] Yes [ ] No

Home:       Cellular: Work:

Please give the telephone number in that a voice mail message may be left. Please remember that cellular phones are not necessarily confidential due to its technology.

Profession/type of work/employment (Adult):

Years in current field of work (Adult):

Adjusted Monthly Income:

Are you currently having financial difficulties:  [ ] Yes [ ] No

Marital Status:  [ ] Married      Yrs  [ ] Never married [ ] Separated

 [ ] Divorced      Yrs  [ ] Widowed      Yrs [ ] Engaged

Household:  [ ] Live alone [ ] Lives with partner and/or children [ ] Live with parents/other family

 [ ] Homeless [ ] Live w. roommate(s)/other [ ] Other

At Risk of Homelessness: [ ] Yes [ ] No

Does consumer have Medicaid? [ ] Yes [ ] No [ ] Applied for, what date:      If yes, please fill in Medicaid # below:

Medicaid # CMO (if applicable) [ ] Amerigroup [ ] Peach State [ ] Wellcare

[ ] State Contracted Services (Only if consumer has no Medicaid/insurance of any kind) [ ]  BCBS

School Setting for Consumer (Check one): [ ] Mainstream [ ] Alternative [ ] Psycho education Center

 [ ] Home School [ ]  Not enrolled in School

Consumer Highest Level of Education:

English Proficiency: [ ] Proficient [ ] Limited–Spanish Primary Language [ ] Limited–Primary Language Other

Communication: [ ] No Impairment Noted [ ] Single Words or Gestures

[ ] American Sign Language [ ] Utilizes language Technology

Parent/Guardian Name:

Address:

Parents: Mother’s Age        [ ] Deceased Yrs.        [ ] Absent/Unknown

 Father’s Age        [ ] Deceased Yrs.       [ ] Absent/Unknown

 Step-Mother Age        [ ] Deceased Yrs.       [ ] Absent/Unknown

 Step-Father Age        [ ] Deceased Yrs.       [ ] Absent/Unknown

Children:

Name : Age: Live with you: [ ] Yes  [ ] No

Name : Age: Live with you: [ ] Yes  [ ] No

Name : Age: Live with you: [ ] Yes [ ] No

Brothers: Ages [ ] None

Sisters: Ages [ ] None

Will family or others participate in your counseling? [ ] Yes [ ] No [ ] Unsure at this time

If so, who: Name: Relationship:

 Name: Relationship:

Presenting Problem/ Reason for service:

Past Counseling Information:

Have you been in treatment or counseling before? [ ] Yes  [ ] No If yes, please give the following info:

Problem: Month/Year: Center:

Were you satisfied with the results: [ ] Yes [ ] No

Problem: Month/Year Center:

Were you satisfied with the results: [ ] Yes  No

Have you had any suicidal or homicidal thoughts now or in the past? [ ] Yes [ ] No

If yes, when:

Did you or have you been thinking about acting on the thoughts?  [ ] Yes  [ ] No

Have you ever been mentally, physically or sexually abused? [ ] Yes  [ ] No

Have you ever mentally, physically or sexually abused someone else?[ ] Yes [ ] No

If yes, to the questions above add any additional information:

Spiritual/Religious background:

Cultural Background**:**

Referral Source:

[ ] Self [ ] DFCS [ ] DJJ [ ] School [ ] Physician [ ] BHL/Crisis Line [ ] Other:

Contact Name: Phone:

Special Population: [ ] Vision Impairment [ ] Hearing Impairment [ ] SSI/Disable [ ] Pregnant [ ] None

Consumer Living Situation: [ ] Private Residence [ ] Foster Home [ ] Group Home [ ] Other:

Substance Abuse Information:

Have you ever used drugs or alcohol? [ ] Yes [ ] No [ ] Unsure If yes, explain:

List the Frequency and usage of drug/alcohol and the last time used:

Do you use Tobacco (snuff, cigarettes, cigars, etc): [ ] Yes  [ ] No If yes, how much a pack a day,       how often.

Legal History:

Have you ever been arrested for domestic violence, DUI, drugs or any other felony? [ ] Yes [ ] No

If yes, Charge(s) & Date(s)

Legal Custody (Check one): [ ] DFCS [ ] Parent [ ] Relative [ ] Other:

Is the consumer currently on probation (If yes, please provide the name of the probation officer and court jurisdiction/obtain phone number of probation officer)

Confidential Medical Information:

Do you have any allergies (medication/food/environmental)? [ ] No [ ] Yes

Medical problems:

Prescribed medications:

Over-the counter medications:

In case of a medical or other emergency, please tell us who you would like us to call:

Name: Relationship: Phone: