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: