Phone: (833) ETC-LIFE
Email: info@empowermentmail.com
9720 Capital Ct, Suite 303
Manassas, VA 20110

Adult Client Intake Packet

Name: ____________________________ DOB: ___________ Date of first appointment: _____________

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible.
All information provided is confidential.

Referred by:
__Medical Provider: ________________________________
__Insurance Provider: ______________________________
__My Website: https://empowerment-therapy-center.com/ PsychologyToday
__Friend/Family: ________________________________
__Other: ________________________________

Have you previously received any type of mental health services? __Yes __No
If yes, which of the following?:
__Psychotherapy __Medication __Outpatient __Hospitalizations __Inpatient Hospitalization

If yes, please provide:
Name of provider or facility:____
Location:____
Dates of treatment:____
Reason for treatment:____

Briefly, what brings you in today?

When did the problem first start? Within the last: __30 days __6--12 months __2 years __During adolescence __During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression? __Yes __No
If yes, for approximately how long? _______________________
***Any Suicidal Thoughts?**__ Current? __Past? - How long ago?________ Notes:___________________________
____
____

Are you currently experiencing anxiety, panic attacks or have any phobias? __Yes __No
If yes, when did you begin experiencing this? _______________________

***Any history of self-harm?** __Current? __Past? – How long ago?_______ Notes:_______________________________________

***Any thoughts about harming others?** __Current? __Past? – How long ago? _______ Notes:______________________________
____
____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

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

Family History

Where were you born? ______________________________________
Where did you grow up? _____________________________________ __City __Suburbs __Country

Please list your **parents** and **siblings**. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____________________________________
Mother's occupation: _____________________________________
Father's occupation? _____________________________________

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, grandmother, uncle, etc.).

Condition	Please Circle	List Family Member
Alcohol/ Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	

Domestic Violence	Yes / No	
Sexual Abuse	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Disorder	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	
Other diagnosed mental health condition?	Yes / No: Which was?:	

Marital Status:

__Never Married __Domestic Partner __Married **If married, how long have you been married for and what is your partners name: ____________________

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

__Separated __Divorced -- For how long? _________

__Widowed: Please provide your partners name and year deceased: ______________________________

Are you currently in a romantic relationship?

__Yes -- How long? _______ On a scale of 1-10 (best), how would you rate your relationship? _____

__No

What is your Gender?_______________ Preferred pronoun(s)?_____________

What is your Sexual Orientation?__________________

Any issues related to gender or sexual orientation that might be relevant to treatment?

Please list any children, their names, and ages:

Name	**Age**	**Relationship**	**Name of other parent**	**If deceased, age and cause of death**

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	**Dosage**	**Condition**	**Date Began/Stopped**

Prescribing provider(s) and contact information:

Name: ____
Specialty: ____
Facility: ____
Phone, email, or Fax: ____

How would you rate your current physical health?
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

Please list any specific and significant health problems you are currently experiencing:

How would you rate your current sleeping habits?
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

If you are having problems, in which phase of sleep are you experiencing issues?
__Falling asleep __Staying asleep __Awakening early __Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? ____________ What types of exercise do you participate in?:

Are you currently experiencing any chronic pain? __No __Yes If yes, please describe:

Substance Use

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

Occupation:____________________________
What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your weaknesses?

What do you consider to be some of your strengths?

Reviewed by (Therapist/Supervisor): ______________________ ____________________________ ________

Print Signed Date

See biopsychosocial assessment for additional notes

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Patient Acknowledgement

Receipt of Patient Agreement

Please sign, print your name, and date this acknowledgement form.

By signing below, I hereby acknowledge that I have been provided with the *Empowerment Therapy Center's* (ETC's) ***Patient Agreement***. The *Patient Agreement* is available at any time on the ETC website located at:

http://empowerment-therapy-center.com

I may also obtain a copy from my ETC therapist upon request, or by ETC, or may access a copy for review in the ETC waiting room. The Patient Agreement includes explanations of the following:

Consent for Treatment

Notice of Privacy Practices

Financial Policy

General Office Policies

"I (Guardian, if patient is a minor)______________________________have read in full, have been provided adequate opportunity to clarify any questions, understand, and agree to the Empowerment Therapy Center's **Patient Agreement**. I also understand that the Patient Agreement may be modified without notice. I will discuss these policies with my (or the child's) therapist, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services."

Patient/ (or guardian if minor) Signature: ____

Patient Name: ___________________________ Guardian (if minor) Name: _________________________________

Witness Signature:____ Date: __________Patient DOB:____________

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RELEASE OF MEDICAL INFORMATION

Date of Release_________________

Dear Dr.______________________(Primary Care Physician),

We are currently working with your patient, ____________________________, (DOB:____________) in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client's latest physical health information.

Our mailing address is: Empowerment Therapy Center, etc, PLLC
9720 Capital Ct, Suite 303
Manassas, VA 20110

Our fax number is: 833-382-5433

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

____ _________________
Signature of Client/Guardian Date

____ _________________
Signature of Staff Witnessing Date

Date Sent to PCP: ____________

Clinician: Please complete this form and either fax or mail a copy of this form to the above-mentioned doctor. Scan this completed form with the date sent in the client's chart.

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GENERAL RELEASE OF INFORMATION

CLIENT NAME: _______________________________ DOB _________ Date of Release: ______________

I hereby give my written permission for *Empowerment Therapy Center, etc* to exchange the following verbal or written information as indicated with: ____ (Name or Entity).

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

__ Discharge Summary __ History & Physical __ Psychiatric Evaluation __ Progress notes

__ Medical Records __ Lab Work __ Consultations __ Treatment Plan

__ School Records __ Psychological Evaluation __ Case Coordination __ Medication Management

__ Diagnostic Information __ Treatment Recommendations

__Other:____
__

Date and/or condition when release will expire: __________________

If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

*As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (parent signature if client is a minor) ______________________________Date:_________

Staff Witnessing Signature_________________________________Date:___________

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CONFIDENTIAL

CREDIT CARD INFORMATION FORM

Name of Client:______________________________

Name of Card Holder (as it appears on card):______________________________

VISA__   MASTERCARD__   DISCOVER__   AMEX__   (HSA cards are fine)

Credit Card #____ Exp Date:___________
CCV:_______

Zip code associated with this card (billing zip):_____________

I, _________________________, authorize *Empowerment Therapy Center* to charge this card for:

__ copayment(s)/ co-insurance(s) due, or

__for a one-time payment in the amount of: $_____________

Signature:___________________________________ Date:_____________