Date_____ **ADULT**

Name_____Birth date_____ Sex M F

Last First MI

Address _____

Soc Sec # _____Phone (H)_____(C)_____

(W)_____

Marital Status: Never married Married Partnered Separated Divorced Widowed

Primary Care Physician _____ Phone # _____

Employer_____ Insurance Co _____

Group#_____ ID#_____

Name/DOB of person who carries insurance _____

Relationship to Client _____

Emergency Contact/Phone #/Relationship to client_____

Guardian/caseworker/Phone #'s_____

Who referred you to the Acacia Center? _____

Why are you coming to the Acacia Center?_____

____ Depression/sadness/tearfulness ____ Worry/stress/anxiety/panic/fear ____ Ager Problems

____ Family/relationship issues ____ Work/Social/School problems ____ Sleep problems

____Health (pain, smoking, obesity, etc.)____ Substance Use ____Legal Problems ___ Sexuality

____Other (describe) _____

Do you have thoughts of not wanting to live? Hurting yourself? Hurting someone else? Have you ever attempted suicide, hurt yourself on purpose, or overdosed? _____

Do you have any medical problems that significantly affect your life? Yes/No_____

_____

On a scale of 1-10, (1="none") how would you rate your day-to-day pain level?_____

Do you use tobacco in any form? _____ If yes, how much do you use per day? _____

Do you drink alcohol? _____ If yes, how many drinks per day? _____

Do you use illegal drugs or misuse prescription drugs? _____

# and ages of children _____

Any problems in current relationship(s) or living situation? _____

_____

Did you experience emotional, physical, or sexual abuse, or death in the family as a child?_____

_____

Highest level of education _____ How was your school experience? Good / Fair / Poor

Have you ever been in the military? _____ If yes, was your experience Good / Fair / Poor?

Have you experienced emotional, physical, or sexual abuse, or death in the family as an adult?

_____

Have you ever been in counseling or mental health treatment before? Yes / No

Reason

_____

Where and when have you received treatment previously? _____
_____
_____

Over the past 2 weeks, have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly everyday |
|---|---|---|---|---|
| No interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the paper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not at all difficult _____
Somewhat difficult _____ Very difficult _____ Extremely difficult _____

**Current Medications/Dosage (continue on back if necessary)** **Prescribing physician**

_____
_____
_____
_____
_____
Any significant side effects?_____
_____

# ACACIA CENTER FOR HUMAN GROWTH AND DEVELOPMENT, INC.

NAME: _____DATE: _____

## *Medications*

*Include vitamins/supplements, herbs, and over-the-counter*

| Medication | Strength | Frequency/daily | Reason for taking medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Application for Services

I hereby voluntarily request care and treatment for _____ by Dr. D. Shaner Gable, Ph.D., H.S.P.P., Dr. Carolyn B Hines, Ph.D., or one of the therapists under their supervision. I am authorizing Drs. Gable and Hines or one of their mental health professionals to administer such treatment as may be deemed necessary and/or advisable. I understand that I have the continuing right to explanation of the nature and purpose of the treatments as well as possible alternative methods and possible risks involved. I also understand that I may voice any dissatisfaction with treatment without penalty, and may request a change of therapist or refuse any treatment offered.

I acknowledge that I have been given opportunity to review the HIPAA policies of the Acacia Center and to request a copy of such policies.

Although every effort will be made to obtain payment from my insurance company, in the event that the insurance company denies payment, I understand that I will be responsible for the full amount not paid. I understand that I am financially responsible for any co-pays and/or deductibles set by my insurance company, and that co-pays are due the day of service. I give consent for release of any medical records to my insurance company that are necessary to facilitate reimbursement, and that this consent is valid for the duration of my treatment at Acacia Center.

If I am covering the therapy expenses independently, I agree to pay $ _____ for the first session and $ _____ for each follow up session, as determined by the therapist and the Acacia Center. This payment is due at time of service.

I understand that, if I must cancel a scheduled appointment, a 24 hour notice is expected. I understand that a fee may be charged for late cancellations or failed appointments. I further understand that a pattern of failed appointments may result in discharge from the care of Acacia Center.

Client Signature _____

Printed Name _____ DOB _____

Date _____