First Name:	Last Name:

Choices in Counseling

Adult Admissions Packet

Directions:

This packet is intended for adults that are 18 years old or older. If you are under 18 years old and in the direct care/supervision of a parent or guardian, please complete the Child/Adolescent Admissions Packet.

Please fill-out the entire packet as accurately and completely as possible. This information will be used to help provide you with the best possible treatment while working with Choices in Counseling. The more detailed the information that you can provide in your initial admissions packet the better we can identify your current needs and begin to structure your treatment to address those needs. If a question does not apply to your current situation, please place an "NA" in the space provided for the answer to that question instead of leaving it blank.

ADULT REGISTRATION

Date Initial Appointment Scheduled: (PLEASE PRINT – PLACE "**NA**" IN FIELDS NOT APPLICABLE)

CONTACT INFORMATION

Last Name:	First:	Middle:

Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security#:

Spouse/Partners Name: Living with you full-time? ❑ Yes ❑ No

Relationship: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Separated ❑Widow How Long? _____ Yrs.

Street address:			P.O. Box:
City:	State:	Zip:	County:
Primary Phone: ( )	Secondary Phone: ( )		Other Phone: ( )

Email Address:

Other Contact Method:

For reminder phone calls and scheduling purposes, what is the best way(s) to contact you? (Check all)

❑ Primary Phone ❑ Secondary Phone ❑ Email ❑ Text Message

❑ Other:

When is your preferred time to schedule appointments?

Day (Circle all that apply): Mon. Tues. Wed. Thu. Fri. Sat.

Time (Circle all that apply): Morning Afternoon Evening ANY

REFERRAL INFORMATION

How did you hear about us? ❑ Dr. _____ ❑ Insurance Company ❑ Hospital ❑ Family ❑ Friend

Please Check All That Apply: ❑ Yellow Pages ❑ Internet Listing ❑ Web Page ❑ Other: _____

Name of Individual that Referred You: Phone: ( )

Do you have other family member(s) that are/have been seen here: ❑ Yes ❑ No

If yes, please list:

PRIMARY HEALTH INFORMATION			
Name of Primary Care Physician:			Phone: ( )
Primary Physician Address:			Fax: ( )
City:	State:	Zip Code:	Date Last Seen: / /
Do you have any medical conditions that we should be aware of? ❑ Yes ❑ No ***If yes, please list**:*			
Are you on any medications? ❑ Yes ❑ No ***If yes, please list (Include Name, Dosage, Frequency)***			

EMPLOYER INFORMATION			
Employer:	Occupation:	Phone: ( )	
Employer Address:		Years Employed:	
Employer City:		State:	Zip:

CURRENT SCHOOL/COLLEGE INFORMATION		
School Name:		Grade:
School Address:		
School City:	State:	Zip:
School Phone: ( )	School Fax: ( )	
Highest Grade Completed in School/College:	Primary School Contact:	
School/College Degree:	Primary School Contact Phone: ( )	
School Comments:		

PRIMARY INSURANCE/EAP INFORMATION		
Do you have **primary insurance/EAP** that you would like to have Choices seek reimbursement from? ❑ Yes ❑ No		
Subscriber's Name:	Relationship to Client:	
Subscriber's Address:		
City:	State:	Zip:
Subscriber's Phone: ( )	Subscriber's DOB: / /	
Subscriber's Employer's Name:	Subscribers Social Security#:	
Employer address:	Employer Phone: ( )	
Name of the Insurance/EAP Company:		
Insurance/EAP Customer Care Phone Number(s):		
Group Number:	Policy Number:	Co-pay: $

SECONDARY INSURANCE INFORMATION		
Do you have **secondary insurance** that you would like to have Choices seek reimbursement from? ❑ Yes ❑ No		
Subscriber's Name:	Relationship to Client:	
Subscriber's Address:		
City:	State:	Zip:
Subscriber's Phone: ( )	Subscriber's DOB: / /	
Subscriber's Employer's Name:	Subscribers Social Security#:	
Employer Address:	Employer Phone: ( )	
Name of Insurance Company:		
Insurance Customer Care Phone Number(s):		
Group Number:	Policy Number:	Co-Pay: $

EMERGENCY CONTACT(S)

Please list a family member or relative along with their phone number(s) that can be contacted in case of an emergency.

Name	Relationship	Phone Number

HOUSEHOLD FAMILY INFORMATION

*Please list all members of the family, extended family, and other individuals **currently living in the home***

Name	Age	Relationship	Occupation **or** School & Grade

Comments:

EXTENDED FAMILY SUPPORTS NOT LIVING IN THE HOME

*Please list all members of the family, extended family and others **not living in the home** that should be considered part of treatment*

Name	Age	Relationship	Occupation **or** School & Grade

Comments:

DEVELOPMENT & CURRENT FUNCTIONING

*Please check **all** of the items listed below that apply which may be considered as part of your concerns for treatment.*
Please add additional comments for checked items.

BIRTH/EARLY DEV

- ❑ There were complications with my birth.
- ❑ Could **not** walk independently after 18 months of age.
- ❑ Could **not** speak in sentences by age 3.
- ❑ Could **not** tie shoestrings independently by age 6.
- ❑ Did **not** develop as fast as brothers/sisters.
- ❑ Struggled with pronouncing words correctly.

Please add comments for checked items →

Additional Comments on **Birth and Early Development**:

COMMUNITY

- ❑ Have had contact with the police.
- ❑ Have been charged with a crime as a juvenile/adult.
- ❑ Have shoplifted from a store.
- ❑ Have stolen items from friends/neighbors.
- ❑ Have been caught vandalizing property.
- ❑ Have damaged others property intentionally.
- ❑ Have been involved in other illegal activities.
- ❑ Other family members have had legal issues.

Please add comments for checked items →

Additional Comments on **Community**:

FAMILY/RELATIONSHIPS

- ❑ Family has experienced stress.
- ❑ Have experienced a recent loss or death.
- ❑ Frequently argue/fight with other family members.
- ❑ Have struggled with marital difficulty.
- ❑ Have recently been separated.
- ❑ Have been remarried.
- ❑ Struggle with providing effective discipline.
- ❑ Family struggles with financial concerns.
- ❑ Family has concerns with the safety of the home.
- ❑ Reports of abuse/neglect have been made.

Please add comments for checked items →

Additional Comments on **Family**:

SOCIAL BEHAVIOR

- ❑ Do not have friends my own age.
- ❑ Withdraw from others in the community.
- ❑ Do not have positive relationships with peers.
- ❑ Do not have positive relationships with other adults.
- ❑ Do not have hobbies or interests that I enjoy.
- ❑ Engage in mainly inappropriate interactions with peers.

Please add comments for checked items →

Additional Comments on **Social Behavior**:

EMOTIONS/HARM

- ❑ Have experienced a trauma.
- ❑ Have had a dramatic change in mood/emotions recently.
- ❑ Frequently worry.
- ❑ Frequently angry.
- ❑ Have had frequent nightmares.
- ❑ Am often sad, tearful.
- ❑ Struggle with low self-esteem.

Please add comments for checked items →

Additional Comments on **Emotions**:

MENTAL HEALTH

- ❑ Have had a history of counseling.
- ❑ Have been hospitalized for mental health.
- ❑ Have had a history of med management.
- ❑ I am currently taking medications.
- ❑ There is a family history of mental health.

- ❑ Have attempted to harm myself
- ❑ Have talked about harming myself
- ❑ Have harmed someone else
- ❑ Have talked about harming someone else

Please add comments for checked items →

Additional Comments on **Mental Health**:

PHYSICAL HEALTH

- ❑ Have struggled with a chronic physical health condition.
- ❑ Have been hospitalized for physical health.
- ❑ Have had major surgery.
- ❑ Have had significant injuries.
- ❑ Struggle with ongoing physical pain.
- ❑ Have allergies.
- ❑ Am on a special diet.

- ❑ Have abused drugs or alcohol*

Please add comments for checked items →

Additional Comments on **Physical Health**:

SPIRITUAL/CULTURAL

- ❑ I have spiritual/cultural beliefs that I would like to have observed as part of my counseling.

Please add comments for checked items →

Additional Comments on **Spiritual/Cultural**:

STRENGTHS AND GOALS FOR TREATMENT

STRENGTHS	What strengths do you feel that you have?

1. _____
2. _____
3. _____
4. _____

GOALS FOR TREATMENT	What goals do you have for your individual/family counseling?

1. _____
2. _____
3. _____
4. _____

Additional comments/questions for therapist consideration:

Note:

- Please be sure that you have filled-out the entire Adult Registration Packet as accurately and completely as possible. If you are in need of additional space to more fully explain your history please feel free to attach additional pages with these comments.

- If you have any difficulty or questions with any part of the registration packet, please feel free to note these questions for further review at the time of your first appointment or contact our office at (317) 346-6252 to speak with someone directly.

- Please bring your completed paperwork to your first appointment along with your primary insurance information (and secondary if applicable) and insurance card(s) as we will make a copy of this information for our records.

By signing below I agree that all of the information contained in this registration packet (pages 1-9) is accurate and has been completed to the best of my ability. My signature below indicates that I fully understand and agree to comply with all terms and conditions outlined in the Client Rights and Responsibilities document available through the Choices in Counseling web site at: www.ChoicesInCounseling.com and/or by request at the Choices in Counseling office.

I authorize my insurance benefits to be paid directly to the appropriate clinician through Choices in Counseling. ***I fully understand that I am financially responsible for any balance that remains on my account regardless of circumstances.*** *I also herby authorize the appropriate clinician through Choices in Counseling and any insurance company(s) listed above to release any information required to process my claims. My signature also confirms that I have read my Client Rights and Responsibilities and fully understand my rights and responsibilities as a client of Choices In Counseling.*

The undersigned certifies that he/she has read and understands the foregoing, is the client, or the client's legal guardian, and agrees to and accepts the terms above.

Client/Guardian Signature	Date	Witness Signature	Date

Printed Name

Relationship to Client