FAMILY FIRST PSYCHOTHERAPY SERVICES (FFPS)

INTAKE & CONSENT FORM

INSTRUCTIONS: Please PRINT and complete ALL information in ink.

EAP Counselor: _____ Case #: _____

CLIENT DEMOGRAPHIC INFORMATION			
Client Name: *(Last, First, MI)*		Appointment Date: *(mm/dd/yyyy)*	Appointment Time:
Date of Birth: *(mm/dd/yyyy)*		Age:	☐ Male ☐ Female
Home Address: *(Street, City, State, Zip Code)*			
Please indicate if you can be reached by telephone at: ☐ Work ☐ Home ☐ Cell			
Phone:	*(work)*	*(home)*	*(cell)*
Email:			
Please note any special instructions about contacting you by telephone or email (e.g., "do not leave message at work"):			
Marital Status: ☐ Single ☐ Married ☐ Committed Partnership ☐ Separated ☐ Divorced ☐ Widowed How long? _____			
Do you have children? ☐ Yes ☐ No If yes, how many? _____ # of Girls: _____ Ages: _____ # of Boys _____ Ages: _____			
Education: ☐ High School/GED ☐ Some College ☐ Associate's ☐ Bachelor's ☐ Some Graduate School ☐ Master's ☐ Doctorate ☐ Other (please specify): _____			
Ethnicity: ☐ African American/Black ☐ Caucasian/White ☐ Native American/Alaskan Native ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other (please specify): _____			
Employee Job Title: _____ Agency: _____ Length of Service:_____ Health Insurance Carrier: _____ Type: _____ VA Benefits? _____			
Emergency Contacts Name: _____ Relationship: _____ Phone: _____ Name: _____ Relationship: _____ Phone: _____			

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REFERRAL SOURCE

Referred by: ☐ Self ☐ Employer ☐ Friend ☐ Family ☐ Psychology Today ☐ Google Search
☐ Website ☐ Other (please specify): _____

Name of Referral:	Phone:

Please provide a brief description of the problem you are having:

MEDICAL HISTORY

Do you have any major/chronic health problems? ☐ Yes ☐ No
If yes, please list them: _____

_____

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list the medication(s) you are taking in the table below:

Medication Name	Reason for Medication	Prescribed by:
		☐ Medical Doctor ☐ Psychiatrist
		☐ Medical Doctor ☐ Psychiatrist
		☐ Medical Doctor ☐ Psychiatrist
		☐ Medical Doctor ☐ Psychiatrist

PREVIOUS COUNSELING/TREATMENT

Please check all that apply: ☐ None ☐ Outpatient Counseling ☐ Outpatient Substance Abuse
☐ Self-help/Peer Support ☐ Inpatient Psychiatry ☐ Inpatient Substance Abuse ☐ Psychotropic Medication

Diagnosis from Previous Counseling/Treatment:

Date(s):_____
Name of Clinician(s): _____

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CURRENT SUBSTANCE USE

Alcohol Frequency:

☐ Never ☐ Less than 1 time/month ☐ 1-4 times per month ☐ 2-3 times per week ☐ Daily

Typical Alcohol Consumption:

☐ None ☐ 1-2 drinks per sitting ☐ 3-4 drinks per sitting ☐ 5 or more drinks per sitting

Drug Use:

☐ None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Stimulants (e.g., amphetamines)

Prescription Medication *(please specify):* _____

☐ Other *(please specify):* _____

Drug Frequency:

☐ Never ☐ Less than 1 time/month ☐ 1-4 times per month ☐ 2-3 times per week ☐ Daily

☐ Other *(please specify):* _____

CURRENT EATING HABITS

Appetite *(How often do you eat daily?):*

☐ Less than 1 time daily ☐ 1-6 times daily ☐ 2-3 times per day ☐ Fasting ☐ Does not eat daily

Sleep Hygiene *(how many hours of sleep a night):*

☐ 0-4 hours ☐ 4-6 hours ☐ 8-10 hours ☐ Sleep all night ☐ Wake-up in the middle of the night?

Do you use prescription medication to sleep? *(please specify):* _____

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Please circle the number that indicates how often you have been concerned by each of the following during the last month.

	None of the time	Some of the time	Most of the time	All of the time
Feeling anxious or stressed	0	1	2	3
Feeling sad or depressed	0	1	2	3
Sleeping problems	0	1	2	3
Appetite problems	0	1	2	3
Physical health concerns	0	1	2	3
Work-related concerns	0	1	2	3
Problems with supervisor	0	1	2	3
Feeling harassed/bullied	0	1	2	3
Feeling irritable	0	1	2	3
Losing your temper	0	1	2	3
Feeling angry	0	1	2	3
Career concerns	0	1	2	3
Worry or fear of losing control	0	1	2	3
Feelings of hopelessness	0	1	2	3
Thoughts of suicide	0	1	2	3
Thoughts of hurting others or animals	0	1	2	3
Relationship concerns	0	1	2	3
Marital or partner problems	0	1	2	3
Financial problems	0	1	2	3
Being treated unfairly	0	1	2	3
Concerns about your past	0	1	2	3
Concerns about child(ren)	0	1	2	3
Legal problems	0	1	2	3
Feelings of loneliness or helplessness	0	1	2	3
Concerns about sexual identity	0	1	2	3
Past or current physical or sexual abuse	0	1	2	3
Spiritual concerns	0	1	2	3
Racial concerns	0	1	2	3
Concerns about alcohol or drug use	0	1	2	3
Concerns about others *(please specify):* _____	0	1	2	3

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I hereby give my consent to be seen by a behavioral health professional associated with Family First Psychotherapy Services Employee Assistance Program (FFPS EAP). I understand that the EAP provides problem assessment and when clinically appropriate, short-term counseling. I also understand that should it be necessary for me (or my insurance eligible family members) to be referred outside the EAP (for example, medication consultation), the EAP will assist me in finding an appropriate referral source, which I can afford. However, I understand that EAP cannot assume responsibility for the results of such referrals.

I understand that all information provided to the EAP will be held confidential within the program to the fullest extent permitted by law. I understand that records of my care with the EAP are kept secured in the EAP office an no information about my visits to EAP will be shared without my written permission (other than grouped statistical data that will not identify me by name). Communications between an Employee Assistance Counselor, Substance Abuse or Medical Professional are confidential and will not be released without the expressed authorization of the client. I understand that certain disclosure or communications may be mandated by law and these include: (a) situations in which an Employee Assistance, Mental Health, Substance Abuse or Medical Professional believes his/her client is a threat to self or others; or (b) when the Mental Health Professional believes there is evidence of child abuse or abuse of the elderly; or (“c) when court ordered, during which time the client will be notified of the request prior to responding.

By signing below I also acknowledge that the FFPS EAP requires notification to cancel or reschedule an EAP appointment.

I understand that if I am not satisfied with the services provided by FFPS EAP, I may contact my EAP Counselor or speak directly to the referring EAP Program Manager. That information was given to me through my employer or private insurance.

I also acknowledge that I have read and understand the EAP Notice of Privacy Practices.

_____ _____

Signature of EAP Client Date

(If the client is a minor, the custodial parent or legal guardian must sign above. Please indicate full name of minor below)

_____

Name of Minor