



LARRY M. FURR MAC, MBA, NCC, LPC
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INTAKE FORM

Client Full Name _____
Address _____ City _____
State _____ Zip Code _____ Home Phone _____
Cell Phone _____ Date of Birth _____ SS# _____
Email Address _____
Emergency Contact Name/Address/Phone _____

Employer/School _____
Employer/School Address _____
Position _____ Length of Service _____
Referred by _____

Insurance Company/Address _____
Policy Holder _____ Relationship to Insured _____
Policy # _____ Group _____
Co-Pay Amount _____ Insured Employer's Name _____
Insured Address _____
Secondary Insurance _____
Group# _____

If your counseling is being provided through an Employee Assistance Program, please provide authorization number and number of sessions authorized.

EAP Company _____ Authorization # _____

Please Initial each statement:

Payment is due prior to each session _____

I understand I will be provided a receipt of services statement and that it is my responsibility to request reimbursement from my insurance company _____

Returned check fees are \$35 plus the check amount _____

Fees are \$ _____ for each session _____

You will be charged \$50 for missing an appointment without prior notification _____

Unpaid balances will be charged a 1 and ½ % interest rate each month _____

*I have received the treatment agreement and accompanying disclosure statement . I have read and understand these documents and agree to abide by these financial responsibilities.*_____

I further authorize Larry M. Furr, MAC, MBA, NCC, LPC Licensed Professional Counselor to release and/or obtain privileged and confidential information about my case as specified below (check all that apply):

- _____ Any and all information including primary care physician
- _____ Counseling and/or assessment records
- _____ Case summary
- _____ Attendance at Counseling
- _____ Synopsis of previous therapy and mental health treatment
- _____ Periodic reports of progress including attendance, compliance, and session's termination
- _____ Specific type of information released _____
- _____ Other _____

Name of person or Organization/Department with whom information will be (Check all that apply):

- _____ Released To
- _____ Obtained From
- _____ Exchanged with

Name _____ and anyone else from their organization

Organization _____

Address _____

Position _____ Email _____ Phone _____

In signing this form, I acknowledge that I know what information is being disclosed or requested. I understand that my records are privileged and confidential and cannot be disclosed without my written consent unless required by law. I also understand that I may revoke this consent at any time except to the extent that action has been taken.

If the client is your child and you have legal permission to sign for them, print their name Here and sign below: _____

Client Signature	Print Name	Effective Date of Release
Spouse Signature	Print Name	Effective Date of Release
Therapist's Signature	Larry Furr LPC	Effective Date of Release

Please describe why you have come in today and the goals you wish to accomplish

Please circle all the terms that describe you today:

Trustworthy Listens Well Kind Sense of Humor Flexible Spontaneous
 Courageous Forgiving Enjoys Learning Walks Erect Calm Fun
 Happy Most of the Day Good Communication Skills Living with Purpose
 Up to Date Decisive Organized Financially Stable Team Player
 Does Not Make Assumptions Does Your Best Everyday Friendly
 Eats Nutritious Balanced Foods Articulate Generous Focus's on Others
 Exercises Spiritual Strong Relationships Good Job Varied Interests

Please circle all items you want to improve:

Marriage Concerns Improve Communication Skills Intimacy Concentration
 Health Concerns Self Esteem Hopelessness Guilt Temper Depressed
 Self-Control Harm to Self Finances Impulsiveness Work/Career
 Harm to Others Energy Level Unhappy Suicidal Concerns Headaches
 Lack of Motivation Memory Legal Matters Sleep Problems Dreams
 Repetitive Thoughts education Needs Night Mares Trauma Anxiety
 Fears Stress Meaninglessness Crying Spells Appetite/Weight Panic Jealousy
 Helplessness Spiritual Concerns Use of Time Eating/Food Infidelity/Affairs
 Divorce/Transition Housing Hording Sexual Performance Verbal Fighting

Health

Please list all Medications/Vitamins _____

Please list all current health problems including allergies: _____

Please list all past health problems _____

Have you ever been hospitalized? ___ If yes, please provide dates and treatment outcomes _____

Have you ever received counseling? ___ Please list dates/ provider/outcomes _____

Name of Primary Care Physician _____

Phone Number _____

Alcohol Usage

Do you or anyone in your household use drugs or alcohol? _____

If so, please describe _____

Your frequency of alcohol use _____ per week _____ drinks per sitting

Frequency of Intoxication _____ never _____ less than 1 per month

_____ 1-4 times per month _____ 2-3 times per week _____ daily

Self-perception of alcohol use (check all that apply) _____ Occasional/Social

_____ Problem Use _____ Addicted/Can't Stop _____ Do Not Want to Stop

_____ motivated

History of Treatment (check all that apply)

_____ None _____ Stopped on Own _____ Attended AA other 12 step

_____ Attended Outpatient Program _____ Attended Inpatient Program _____ Other

Which Program? _____

Please describe any alcohol related problems (i.e. legal, relational, job, physical, social)

Substance Usage

Please check frequency and duration of use

Substance	Daily	Weekly	Monthly
Marijuana			
Sedative			
Stimulants			
Cocaine			
Opiates			
Inhalants			
Hallucinogens			
Caffeine			
Prescription Meds			
Tobacco			
Other			

Please describe any drug related problems(i.e. legal, physical, job, relational, social, etc)

Self perception of Drug Use (check all that apply)

Occasional or Social Problem Use Addicted, Can't Stop
 Does Not Want to Stop Motivated

History of Treatment Attempts (check all that apply)

None Stopped on Own Attended AA/other program
 Attended Outpatient program Attended Inpatient Program
 Which program? _____

Married _____ Divorced _____ Living Together _____ Separated _____
Single _____ Other _____
List dates and lengths of any previous marriages _____

Have you ever been convicted of a felony/misdemeanor? Yes _____ No _____
Please explain _____

Do you have a probation officer/case worker? Yes _____ No _____
If Yes -Name/Address/Phone _____

Do you have an Attorney? Yes _____ No _____ Attorney's Name/Address/Phone _____

Spiritual Values
Please List Three Beliefs That Support Your Life

- 1. _____
- 2. _____
- 3. _____

Please list the Names, Ages and Relationships of all persons living in your household:

Your Therapist will develop a family genogram with you.

Please Initial

To enable my Therapist with accurate and confidential contact please note that:

Messages regarding appointments may be left on my voice mail _____

The following individuals may schedule or confirm appointments for me

To Be Completed By Therapist

Procedure Code: _____ Primary DX _____ Secondary DX _____

Axis III IV V _____

THANK YOU FOR COMPLETING THIS INTAKE FORM.

