

SERVICE INTAKE FORM
NewDirectionsColumbus.com 614-832-3355



Our fee for Individual, Couples, and Family Counseling services is \$55.00 per 50 minute session. Our fee for mental health/substance abuse assessment is \$110. We currently accept cash, check, or money order for services, but we do not accept insurance for payment. Our self-pay policy provides for lower service rates, treatment flexibility, and a heightened level of confidentiality. Payment is due at the start of the session. Sessions canceled less than 16 hours before the scheduled time will be billed at the full rate. PLEASE INITIAL _____

How did you hear about New Directions Counseling Services? _____

If anyone is at risk for immediate harm contact 911 or Netcare Access [Crisis Hotline] at 614-276-2273 - www.netcareaccess.org

Individual making contact with New Directions Counseling Services:

1] Name: _____ Gender: _____ Age: _____ DOB: _____
 Single Married Divorced Living Together Widowed Married but separated Pending Divorce
 Occupation: _____
 Address: _____
 Phone & E-mail: _____

Describe why counseling is being sought:

Family Members

Significant Other - Name: _____ Gender: _____ Age: _____ DOB: _____
 Occupation: _____
 Phone & E-mail: _____

Others in the Home

	Name	Relationship to Client	Gender & Age	Comments
1				
2				
3				
4				
5				
6				
7				

Other Pertinent Family Information:

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Mental Health or Drug & Alcohol Abuse Treatment History of the Identified Client

Outpatient Treatment None Reported

Agency & Type of Program	Successful Completion?	Dates	Clinician Name

Residential Treatment /Psychiatric Hospitalizations Facilities None Reported

Facility	Dates	Reason (Drugs/Alcohol, suicidal, depressed, etc.)

Previous or Current Diagnoses (if known) Not Known by Client

None Reported **Current Psychotropic or Pain Medication Information** (prescription/OTC/herbal)

Medication	Rationale	Dosage/Route/Frequency	Compliance			
			Yes	No	Partial	Unk
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Primary Care Physician (name, phone no., and address)

None Reported **Past Psychotropic Medications**

Psychotropic Medications	Reason for Discontinuation

Drug Use History

	Drug/Alcohol Name	Age of First use	Last Used	Frequency of use	Typical Amount
1					
2					
3					
4					
5					
6					

ABUSE HISTORY

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> No Self Reported History of Abuse/Violence | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence/Abuse | <input type="checkbox"/> Community Violence |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Elder Abuse | <input type="checkbox"/> Sexual Abuse/Molestation |
| <input type="checkbox"/> Rape: | <input type="checkbox"/> Other: | | |

Past & Current Legal Issues:

Any life threatening concerns, medical conditions, or other pertinent information [add a blank page if necessary]: