

Price Counseling Center

2920 Marietta Hwy, Ste 132
Canton, GA 30114
770-479-5501

NEW CLIENT INFORMATION & REGISTRATION CONFIDENTIAL

Please respond completely and accurately to the following items so that we might be better able to serve you. If an item does not apply to you, please place "N/A" in the space. Thank you for your time and cooperation. WELCOME TO OUR PRACTICE!

CLIENT'S NAME: _____ DATE: _____
(Last) (First) (Middle)

How would you like to receive your evaluation (circle one): **MAIL** **EMAIL** **PICK UP**

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Driver's License No: _____

Date of Birth: _____ Current Age: _____ Social Security No: _____

Marital Status: _____ How long? _____ Race: _____

Client's Nearest Relative (in case of emergency):

Name: _____ Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____

Please list the names **and ages** of any children or other persons residing in client's household:

Probation Officer: _____ Phone No. _____

Address: _____ City _____ State _____ Zip _____

Attorney: _____ Phone No: _____

Address: _____ City _____ State _____ Zip _____

DFCS Caseworker: _____ Phone No. _____

**ALCOHOL/DRUG QUESTIONNAIRE
ADAPTED MAST**

To be filled out if at any point in your life this information has been true.

1. Please list any drugs you have ever used besides alcohol:

Yes	No	Drug	Last use
Yes	No	Marijuana	_____
Yes	No	Cocaine (crack, powdered, freebase)	_____
Yes	No	Methamphetamine or Amphetamines (Crank, Ice, "Nazi dope")	_____
Yes	No	Tranquilizers (Xanax, Ativan, Valium, etc)	_____
Yes	No	Ecstasy (MDMA)	_____
Yes	No	Pain pills (Oxycontin, Demerol, Dilaudid, etc)	_____
Yes	No	LSD, PCP, "K", peyote	_____
Yes	No	Steroids	_____
Yes	No	Research Chemicals	_____
Yes	No	Other _____	_____

2. The day after using any substance, have you ever experienced agitation, tremors, headache, nausea, hallucinations, skin crawling, or seizures? (Please circle those that apply.)

3. What is your most preferred drug? Include alcohol _____
How do you use your drug of choice? _____

Yes	No	4. Have you ever awakened the morning after alcohol or drug use the night before and found that you could not remember a part of the evening before?
Yes	No	5. Does your spouse (or do your parents) ever worry or complain about your alcohol or drug use?
Yes	No	6. Can you stop drinking or taking drugs without a struggle after one or two drinks, hits, pills, etc?
Yes	No	7. Do you ever feel bad about your use of alcohol or drugs?
Yes	No	8. Do you ever try to limit your use to certain times of the day or to certain places?
Yes	No	9. Are you always able to stop using or drinking when you want to?
Yes	No	10. Have you ever attended a meeting of Alcoholics Anonymous (AA), NA, CA?
Yes	No	11. Have you gotten into fights when using or drinking?
Yes	No	12. Has using/drinking ever created problems with you and your wife, girlfriend, boyfriend, etc.?
Yes	No	13. Has your spouse (or other family member) ever gone to anyone about your use of alcohol or drugs?
Yes	No	14. Have you ever lost friends or girlfriends/boyfriends because of alcohol or drug use?
Yes	No	15. Have you ever gotten into trouble at work because of drinking?
Yes	No	16. Have you ever lost a job because of drug or alcohol use?
Yes	No	17. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking or drugging, or recovering?
Yes	No	18. Do you ever drink before noon, or use drugs in the a.m.?
Yes	No	19. Have you ever been told that you have liver trouble? Cirrhosis, lung problems or stomach problems? Skin problems, tooth decay due to drug use?
Yes	No	20. Have you ever gone to anyone for help about your use of alcohol and/or drugs?

Yes No 21. Have you ever been in a hospital because of physical injuries you suffered from alcohol and drug use?

Yes No 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where substance abuse was part of the problem?

Yes No 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drugs or alcohol played a part?

Yes No 24. Have you ever been arrested, even for a few hours, because of behavior induced by substance abuse, such as public intoxication, fighting, BUI, etc?

Yes No 25. Have you ever been arrested for driving after using alcohol?

Yes No 26. Have you ever been arrested for DUI after using drugs?

Yes No 27. Have you ever failed a drug screen at work?

Yes No 28. Have you ever used alcohol or drugs while on probation?

Yes No 29. Have you ever passed up a job because you didn't want to be drug screened?

Yes No 30. Have you ever sold drugs?

Yes No 31. Have you ever had an open case with a local DFCS agency which involved drug use?

Yes No 32. Have your children ever been removed from your home because of drugs?

Yes No 33. Have you ever had a meth lab in your home, car, storage facility, out building?

Yes No 34. Have you ever failed a drug screen as part of a DFCS investigation?

Yes No 35. Have you ever refused a drug screen which was part of a DFCS investigation?

Yes No 36. Have you ever stayed up for 24 hours or more using drugs?

Yes No 37. Have you ever "overdosed"? If so, on what? _____

What is the longest period of time that you have been under the influence? _____
If so, on what? _____ ?

Have you ever been administered Narcan? _____ If so, how many times? _____ ?

List your arrests - lifetime (include dates):

I understand that if I am untruthful on any part of my evaluation, the evaluation will be invalid. I may have to repeat the evaluation and pay another fee.

I understand that if I see someone I know in the office or in a group session, I will honor their confidentiality as they will honor mine.

***I understand that evaluations and counseling as part of a court ordered, court referred, or probationary program are not covered under insurance and the balance due is my responsibility to pay at the time of service.

***** I also understand that this evaluation is only valid for six months. If treatment is recommended, I must begin and complete treatment before six months of the date of my evaluation, or sooner if required by the court, counselor, or probation officer.**

Client Signature

Date

BEHAVIOR IN SESSION

I understand that I am being referred to an introductory counseling program as part of my probation or legal situation. This program does not claim to treat underlying psychological problems or severe depression. If I have other issues, it is my responsibility to speak to my therapist about them and an additional program will be outlined for me.

Client's Signature

Date

APPOINTMENTS AND CANCELLATIONS

Our appointments are generally 30-50 minutes. It is not our policy to "double book" appointments so our time is exclusively committed to your appointment. When an appointment is missed, own schedule is seriously disrupted as I am unable to make this time available to other clients. For this reason we require that you give me 24 hours notice of your intent to cancel or reschedule an appointment. **If you cancel an appointment without 24 hours notice, or if you miss an appointment, you will be charged for the session.** These charges are not covered by insurance and are due at the next scheduled appointment, or within two weeks of the cancellation. My signature below indicates that I have read and understand the information regarding appointments and cancellations. If you elect to pay by credit card, if the credit card is not in your name, we reserve the right to communicate with the owner of the credit card for matters of finance only.

Client's Signature

Date

THE PRICE COUNSELING CENTER

Grace Riley Price, L.C.S.W.

RELEASE OF INFORMATION

NAME OF PATIENT: _____

The Price Counseling Center is hereby authorized to release to and/or receive from:

Name: _____

Contact Information (address, email, etc.): _____

the following documents and/or information (please initial all that apply):

Notification of Initial Contact _____

General Treatment Information _____

Periodic Progress and Evaluation Reports _____

Attendance Reports _____

Other: _____

I hereby release The Price Counseling Center from any and all liabilities, responsibilities, damages and claims which might arise from the release of the information authorized above. I acknowledge that this consent is valid for 6 months. I further understand that I can withdraw this consent for release of information at any time prior to the expiration date by giving written notice to The Price Counseling Center.

Patient's Signature: _____

Date _____

Patient's Representative: _____

Date _____

Witnessed: _____

Date _____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.