Sunrise Counseling

Christine Burrell Townsend, LCSW, ACSW (License #002958)
2386 Clower St. Bldg C-100
Snellville, GA 30078
770 985 2050

Sunrise Counseling is dedicated to the counseling process. I look forward to working with you. Although I cannot guarantee any specific results, we will work together to resolve the issues that have led you to seek my help and support. The nature of the counseling process is very personal. Therefore, we will maintain a professional relationship consistent with accepted ethical standards. You are in complete control and may end our professional relationship at any time.

Name: ____Today's Date: ________________

Date of Birth: ___________________ Age: _________________________

Address: __________________________________City: __________________Zip: _______

Social Security #: _______________________

Telephone: H: ___________W: _____________Cell: ______________

May I leave a message? If so, on which number? ______________

E-mail: __________________ May I e-mail you? ___________Text messaging? _________
*Please note: Email and text message correspondence are not considered to be confidential communication.

Emergency Contact: _________________________ Phone: ____________________

Occupation: _____________________Employer/School: ________________________

Education: ________________________Current Marital Status: __________________

Referral Source: ____

Please describe the reasons for seeking counseling?

How long has this been a challenge for you?

What do you do for fun or to relax?

Have you previously seen a therapist? If so, when? Who was the therapist and about how many sessions?

If appropriate, may I contact this individual? _______________________________

Life Stressors:

Client name: Date

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Please circle the following symptoms affecting you. (Leave blank if not applicable):

Depression	Panic Attacks /Anxiety	Feel Hopeless
Rapid heartbeat/palpitations	Think about suicide	Constant worry or anxiety
Feel irritable	Fear of social gatherings	cry easily
Anger Outbursts	Loneliness	Unwanted / distressing thoughts
Feel guilty	Feeling worthless	thoughts of traumatic events
Phobias, unreasonable fears	Withdrawal from people	Nightmares
Unable to have a good time	Excessive bedwetting	Lost interest in usual activities
Bowel disturbances	Headaches	Peer Problems
Decreased energy/fatigue	Chronic Pain	Inattentive/distractible
Trouble staying asleep	Trouble falling asleep	Memory problems
Trouble waking up	Hyperactivity	Recent weight gain or loss
Racing thoughts	No appetite	Hearing voices
Binge eating	Anxiety	Intentional vomiting
Think about hurting someone	School problems	Repetitive behaviors
Substance abuse	Loss of interest in sex	Unmotivated to complete daily tasks
Repetitive Behaviors	Spending Sprees	Medical issues:

-----**Please explain any of the above:** --

Have you ever had suicidal thoughts? ___ When and what did you do? ____

Have you ever had thoughts about harming others? ________ How? ____

Have you been treated for drug or alcohol abuse? ____________________When/Where? ___________________

Were you ever in a psychiatric hospital? ____

Have you ever been prescribed psychiatric medication? ___________________________________

Are you currently taking any psychiatric prescription medication? _____________________________________

Have you ever been molested?

Current Relationship:

If partnered, for how long: ______________ if married, on what date: _______________

If separated or divorced, please list below:

If a partner is deceased, please give the date and explain the circumstances:

Family:

(List all but indicate which are from a previous marriage or relationship with the letter P in the last column) Add other significant people in your life/family.

Client name: Date

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Name	Current Age	Sex	Education/Employment	Relationship

_

How would you characterize your relationship with your friends/family?

Describe your childhood: (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

List any significant life traumas:

List any significant life influences:

Health/Medical:

Who is your Primary Care Doctor?
Address/Phone:

May I contact this Doctor to coordinate care? Yes No _______________ (initial here)

How is your health?

When was your last complete physical?

Any medical concerns?

Please list any medications, dosages and the reason you are taking them.

Have you had any serious accidents/injuries/illnesses involving such things as (circle): Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, or meningitis? Please explain:

Have you ever been hospitalized? If so, please explain:

How is your appetite?

Have you ever been told you have an eating disorder?

How many hours a night do you sleep?

Are you active (exercise, sports, walking)?

How often do you drink alcohol? Daily (# of Drinks/Day ____)
Weekly (# of Drinks/Wk.____) Infrequently Never

How often do you engage in recreational drug use?
Daily Weekly Infrequently In the Past Never

Client name: Date

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Is there a family history of any of the following?

(Please Check)			(Family Member)
Alcohol Abuse:	yes	no	________________________________
Substance Abuse:	yes	no	________________________________
Depression:	yes	no	________________________________
Suicide Attempts:	yes	no	________________________________
Bipolar Disorder:	yes	no	________________________________
Schizophrenia:	yes	no	________________________________
Eating Disorders:	yes	no	________________________________

Your current education and employer

What is your highest level of Education and/or Degree
Current Occupation: Full time/Part time

Employers name:

Address

How long have you worked here?

Do you enjoy your job?

Any Military/Vocational Training:

Religion:

Religious affiliation: Church you currently attend:

Do you consider faith/religion meaningful in your life?

Drugs/Alcohol:

Are you aware of any drug or alcohol use or abuse by your child? Please explain.

Legal Involvement:

Current:

Past:

Please be aware of my policies about involving me in your legal process –I am not a forensic clinician, who provides psychological services or clinical testimony for the purposes of court related or custody matters. If you are seeking a forensic clinician, please let me know, so I can refer you to a trained and experienced provider. See fees and payments for information about court related involvement.

____

Signature of the person completing this form date

Financial Responsibility: (please provide a copy of your insurance card)

Insurance Carrier: ________________________Phone Number on Card: _____________________

Policy ID Number:______________________________Group Number:________________________

Primary Policy Holder's Name: ______________________________Date of Birth: ____________

Address, if different from Client: ________________

Phone Number, if different from Client______________________

Relationship to Client: ______________________________

Primary Policy Holder's Employer: ___________________________________

Client Acknowledgement of Receipt of HIPPA (Keep pg. 6 of this document)

Notice of Privacy Practices

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices of Christine Burrell Townsend, LCSW, ACSW, and Sunrise Counseling

____
Print Name of Client or Responsible Party (if client is under the age of 18)

____
Signature of Client or Responsible Party

____
Date

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information privacy:

As part of providing professional care, I am committed to maintaining the privacy of your personal health information. I am also required by law to keep your information private. HIPPA (The Health Insurance Portability and Accountability Act) requires that I provide you with this notice of privacy practices.

I will use information about your health mainly to provide you with treatment, to arrange payment for our services, to file claims with insurance companies, and for some other business activities that are legally referred to as "health care operations."

If it will be useful to disclose or release your information for any other purposes, I will ask you to sign an authorization form for release of information.

Your health information is confidential. However, there are instances when the law requires me to share it. For example:

• If there is a serious threat to your health and safety or the health and safety of another individual or the public. I only share information with the person or organization that is able to help to prevent or reduce the threat.

• If there is any suspicion of child abuse, neglect, molestation, or sexual abuse.

• If there is any suspicion of elder abuse or neglect.

• If you are unable to take care of basic needs for yourself.

• If disclosure of your health information is court ordered.

Your rights regarding your health information:

• You can ask me to communicate with you about your health and related issues in a way that is more private for you. For example, you can ask me to call you at work and not at home, or ask me not to leave a telephone message on a home answering machine.

• You have the right to ask me to limit what I tell people who are either involved in your care or the payment for your care, such as family members and friends. I will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.

• You have the right to look at the health information I have about you, such as your treatment and billing records. Please contact me to arrange how to see your records.

• If you believe certain information in your record is incorrect or missing, you can ask me to make some kinds of changes to your health information. You must make this request in writing and tell me the reasons you want to make the changes.

• You have a right to copy of this notice. If I change this notice, I will post the new version on my website or you can obtain a new copy from me.

• You have the right to file a complaint if you believe your privacy rights have been violated. You can contact the United States Secretary of Health and Human Services at:

The Office of Civil Rights U.S. Department of Health and Human Services
200 Independence Avenue S.W. Room 515F, HHH Bldg.
Washington D.C., 20201.

• Filing a complaint will not change the health care I provide you in any way.

If you have any questions regarding this notice or your health information privacy, please discuss them with me. My contact information is:

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