

**The Moore Institute  
4126 Autumn Lane  
Cahaba Heights, Al. 35243**

**Intake Form**

Date: \_\_\_\_\_

Name/S: \_\_\_\_\_

SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Referral Source: \_\_\_\_\_

OK to Call Home  Yes  No

OK to Call Work  Yes  No

When Was the Last Time You Examined by A Physician? \_\_\_\_\_

List Any Major Health Problems:

\_\_\_\_\_

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Past Mental Health Chemical Dependency Treatment Or Counseling:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Reason For This Visit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Problems:

\_\_\_\_\_

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Emergency Notification: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SS No. \_\_\_\_\_ Driver's License No: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

May we contact your previous therapist? Name and city and state?

\_\_\_\_\_

The charges for my services are based on our professional training, expertise and experience and are the usual, customary and reasonable fee profiles for this area. **The Fee for individual services is \$125.00 per clinical hour. For couples the fee is \$150.00 per clinical hour. For the Addiction Recovery Intensive the fee is \$700 a week.** This fee also includes our time on your behalf, including record keeping and preparation. **We encourage you to discuss fees at any time, and our clients are expected to pay for services when provided unless arrangements have been made in advance. We request payment be made out in advance so that our entire time may be spent attending to your concerns. You may pay by check, cash, Master Card or Visa.** When a psychological report is sent to a third party, there is a fee of \$300 per hour, payment in full is necessary prior to release of my findings. Other charges are based on the fee discussed above. If there is an additional charge this fee will be discussed with you before a service is rendered.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

PLEASE SEE HIPPA REGULATIONS POSTED ON DESK IN WAITING ROOM

The Moore Institute  
4126 Autumn Lane  
Cahaba Heights, Al. 35243  
205-967-3277

Welcome to our practice. We are pleased to have the opportunity to serve you and hope that this handout will provide information helpful in making an informed decision concerning our services. Please ask questions at any time.

Both Steve & Pam Moore are Licensed Clinical Social Workers. Pam has a Master's degree and have been counseling individuals, families and groups for over 25 years. Steve has a Master's degree in Social work with a focus in mental health. Pam has training and experience in many areas including individual, family and group therapies for adolescence and adults.

The both have training and experience in many areas including primary addictions, stage two recovery issues, grief, relationships and intimacy.

If our work together leads to problems beyond our training and expertise, we will help you to obtain the necessary services from the appropriate specialist. Our resumes, licenses and credentials are available for review.

### ***APPOINTMENTS:***

Services are available by appointment only. The length of the appointment time varies on the basis of services provided. Individual therapy is generally scheduled for 45 to 50 minutes, and this is known as the "clinical hour." Because the appointment is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance, unless in fact they are occasioned by circumstances which we would both define as an emergency. Failure to provide a 24-hour notice of cancellation generally means that some other person is unable to use that appointment time. There are not set office hours.

**Social Media:** We do not become Facebook friends with clients but do encourage you to like our page The Moore Institute and C3. We keep events updated to both pages regularly. We do not text with clients. This eliminates any communication confusion. It is important for you to leave a clear message with our service. We will return calls during regular business hours. We have also found it is easier to not e-mail with clients, as a phone message guarantees we will not miss information from you and we can more easily guarantee your privacy.

### ***Legal Issues***

It is not the practice of The Moore Institute to provide legal testimony for our clients. We do not provide documentation or records for legal cases. We do not respond to subpoenas. Therefore, if the need for legal testimony is anticipated, we will be glad to refer you to another professional. If we do have to provide documentation or testimony for court proceedings the charge is \$400 per hour door to door.

## **INITIAL CONTACT**

Our initial appointment is often called an “initial evaluation.” This appointment is scheduled for you to discuss your concerns and problems from your point of view. There may be time during this appointment to obtain historical and other background data or this information may be gathered at subsequent sessions. In times of crises, the usual format of an initial evaluation is not followed in the hope that the time might be used to resolve or relieve the immediate crisis. As part of the “initial evaluation” new clients are requested to complete at least one questionnaire concerning their beliefs, experiences, thoughts and feelings. This information will help us in understanding your concerns and problems.

## ***TREATMENT:***

We expect and encourage you to obtain knowledge of the procedures, goal and possible side-effects of psychotherapy. We expect to make our professional contact one where you receive the maximum benefit and will also keep you informed about alternatives to psychotherapy. Psychotherapy may be tremendously beneficial for some individuals while at the same time, there are some risks. The risks may include the experience of intense and unwanted feelings, including: sadness, anger, fear, guilt or anxiety. It is important to remember these feeling may be natural and normal and are an important part of the therapy process. Other risks of therapy might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values, and experiences, alteration of an individual’s ability or desire to deal effectively and harmoniously with others in relationships. In therapy, major life decisions are sometimes made, including: decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. These decisions are a legitimate outcome of the therapy experience because of

an individual’s calling into question many of their beliefs and values. As your therapists, we will be available to discuss any of your assumptions, problems, or possible negative side effects of our work together.

## **ASSESSMENT:**

In addition to the intake administered as a part of the “initial evaluation,” it is often beneficial to conduct a “formal” assessment in the early stages of therapeutic services or in consultation for others. If requested, the assessment will be discussed. A written report can also be provided; however written assessments require additional time to prepare and are more expensive to the client.

## **TERMINATION:**

Termination of psychotherapy may occur any time and may be initiated by either the client or the therapist. We request that if a decision is being made to terminate, that there be a minimum of a seven Termination itself can be a constructive, useful process. If any referral is warranted, it may be made at that time.

## **CLIENTS WHO ARE DEPENDENTS:**

If you are requesting our services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your child's therapist, it is important that our child be able to completely trust us. As such, we keep confidential what your child says in the same way that we keep confidential what an adult says. As the parent or guardian, you have the right and responsibility to question and understand the nature of my activities and progress with your child, and we must use our clinical discretion as to what an appropriate disclosure is. In general, we will not release specific information that the child provides to us; however, we feel it appropriate to discuss with you, the parent or guardian, your child's progress and your participation in their treatment.

**CHARGES:**

The charges for my services are based on our professional training, expertise and experience and are the usual, customary and reasonable fee profiles for this area. The fee for individual therapy is 115.00 per clinical hour, the fee for couple's therapy is \$150.00 per clinical hour, and \$700 a week for the Addiction Recovery Intensive. These fees also include our time on your behalf, including: record keeping and preparation. We encourage you to discuss fees at any time, and our clients are expected to pay for services when provided unless arrangements have been made in advance. Payment can be made by cash, check, Master card or Visa. When a psychological report is sent to a third party, a fee of \$400 per hour, payment in full is necessary prior to release of my findings. We will be glad to give you the forms to file for insurance reimbursement, but payment is due at the time of service. Other charges are based on the fee discussed above.

**Notice of Privacy Practices  
Receipt and Acknowledgment of Notice**

**Patient/Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of The Moore Institute's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact [Steve Moore 205-967-3277

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**Signature of Patient/Client** **Date**

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**Signature or Parent, Guardian or Personal Representative \*** **Date**

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\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

**Patient/Client Refuses to Acknowledge Receipt:**

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**Signature of Staff Member** **Date**

**Adult Intake Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PRESENTING PROBLEMS AND CONCERNS**

Describe the problem that brought you here today: \_\_\_\_\_

Please check all the behaviors a symptom that you consider problematic:

- |                           |                        |                               |
|---------------------------|------------------------|-------------------------------|
| Distractibility           | Change in appetite     | Suspicion/paranoia            |
| Hyperactivity             | Lack of motivation     | Racing thoughts               |
| impulsivity               | Withdrawal from people | Excessive energy              |
| Boredom                   | Anxiety/worry          | Wide mood swings              |
| Poor memory/confusion     | Panic Attacks          | Sleep problems                |
| Seasonal mood changes     | Fear away from home    | Nightmares                    |
| Sadness/ Depression       | Social Discomfort      | Eating problems               |
| Loss of pleasure/interest | Obsessive Thoughts     | Gambling problems             |
| Hopelessness              | Compulsive Behavior    | Computer addiction            |
| Thoughts of Death         | Aggression/fights      | Problems with pornography     |
| Self-harm behaviors       | Frequent Arguments     | Parenting problems            |
| Crying spells             | Irritability/anger     | Sexual problems               |
| Loneliness                | Homicidal Thoughts     | Relationship problems         |
| Low self-worth            | Flashbacks             | Work/school problems          |
| Guilt/shame               | Hearing Voices         | Alcohol/Drug use              |
| Fatigue                   | Visual Hallucinations  | Recurring Disturbing memories |

Other: \_\_\_\_\_

Are your problems affecting any of the following?

- |                         |               |              |
|-------------------------|---------------|--------------|
| Handling everyday tasks | Self-esteem   | Hygiene      |
| Work/School             | Housing       | Recreational |
| Sexual Relationships    | Legal Matters | Finances     |
|                         | Health        |              |

Yes, No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please Describe:

\_\_\_\_\_  
\_\_\_\_\_

Yes, No Have you ever ha thoughts, made statements, or attempted to hurt someone else? If yes, please Describe.:

\_\_\_\_\_  
\_\_\_\_\_

Yes, No Have you recently been physically hurt or threatened by someone else? If yes, please Describe:

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

**FAMILY AND DEVELOPMENTAL HISTORY**

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				Hyper-activity	
Father				Sexually Abused	
Stepmother				Depression	
Stepfather				Manic Depression	
Siblings				Suicide	
				Anxiety	
				Panic Attacks	
				Obsessive-Compulsive	
Spouse/partner				Anger/Abusive	
Children				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

Parents legally married or living together  
 Parents temporarily separate  
 Parents' divorce or permanently separate

Mother remarried : Number of times  
 Father remarried : Number of times

Please circle if you have experience any of the following types of trauma or loss:  
 Emotional abuse      Neglect      Lived in a foster home  
 Sexual abuse      Violence in the home      Multiple family moves  
 Physical abuse      Crime Victim      Homelessness  
 Parent substance abuse      Parent Illness      Loss of a loved one  
 Teen pregnancy      Placed a child for adoption      Financial problems

**PREVIOUS MENTAL HEALTH TREATMENT**

		Type of Treatment	When?	Name of /Program	Reason for Treatment
Y	N	Outpatient Counseling			
Y	N	Medication (mental health)			
Y	N	Psychiatric Hospitalization			
Y	N	Drug/Alcohol Treatment			
Y	N	Self-help/Support Groups			

Yes, No      Have you gamble in the past 6 months? If yes, let us know the following  
 Yes, No      Have you ever felt the need to bet more and more money?  
 Yes, No      Have you ever had to lie to people important to you about how much you gamble ?

Name: \_\_\_\_\_

**SUBSTANCE USE HISTORY**

Substance Type	Current Use (last 6 months)				Past Use			
	y	N	Frequency	Amount	y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LS								
Steroids								
Tranquilizers								

**Yes, No** Have you had withdrawal symptoms when trying to stop using any substances?  
**Describe:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Yes, No** Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? **If yes, please**  
**Describe:** \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL INFORMATION**

Date of last physical exam: \_\_\_\_\_

Have you experience any of the following medical conditions during your lifetime?

- |                              |            |                  |                 |
|------------------------------|------------|------------------|-----------------|
| Allergies                    | Asthma     | Headaches        | Stomach aches   |
| Chronic pain                 | Surgery    | Serious Accident | Head injury     |
| Dizziness/fainting           | Meningitis | Seizures         | Vision problems |
| High fevers                  | Diabetes   | Hearing Problems | Miscarriage     |
| Sexually transmitted Disease | Abortion   | Sleep Disorder   | Other: _____    |

Please list any CURRENT health concerns:-----  
 \_\_\_\_\_

Medication	Dosage	Date First Prescribed	Prescribed By

Name: \_\_\_\_\_

Current over-the-counter medications (including vitamins, herbal remedies, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Allergies and/or adverse reactions to medications:           None

If yes, please list: \_\_\_\_\_

**INTERPERSONAL/SOCIAL/CULTURAL INFORMATION**

Please Describe your social support network (check all that apply):

Family   Neighbors   Friends      Students   Co-workers   Support/Self-Help Group

Community Group      Religious/Spiritual Center (which one?) \_\_\_\_\_

To which cultural or ethnic group do you belong? \_\_\_\_\_

If you are experiencing any Difficulties due to cultural or ethnic issues, please Describe:

\_\_\_\_\_  
\_\_\_\_\_

How important are Spiritual matters to you?

Not at all   Little   Somewhat   Very much

Yes,   No   Would you like spiritual/religious beliefs to be incorporate into your counseling?

Please Describe your strengths, skills, and talents? -----

Describe any special areas of interest or hobbies {art, books, physical fitness, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Employment**

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Length of time in this position: \_\_\_\_\_ Job duties: \_\_\_\_\_

Stress level of this position:   Low            Medium            High

**Education**

Name: \_\_\_\_\_

Yes, No Are you currently attending school? Highest Degree Attained \_\_\_\_\_

**Military Service**

Yes, No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch \_\_\_\_\_ Date of Discharge \_\_\_\_\_ Type of Discharge \_\_\_\_\_ Rank \_\_\_\_\_

Yes, No Were you in combat?

**Legal**

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you currently involve in any divorce or child custody proceedings? Yes NO

If yes, please explain \_\_\_\_\_

\_\_\_\_\_