Harvest Counseling

Glen Keeffe MA, LMHC

CLIENT INTAKE INFORMATION

DATE:____________________ E-MAIL:________________________

IDENTIFICATION DATA

NAME:____ DOB:____________________
FIRST LAST M.I. MO DA YR

ADDRESS:_________________________________
____
____

MAY WE LEAVE A MESSAGE:
PHONE (HOME): ____________ **YES NO**
(WORK): ____________ **YES NO**
(CELL):____________ **YES NO**

REFERRED BY:____

INSURANCE & BENEFIT INFORMATION:

PRIMARY INSURED: _______________________ SECONDARY INSURED:______________________

PRIMARY INSURED DOB: __________________ SECONDARY INSURED DOB: _________________

INSURANCE CO: __________________________ INSURANCE CO: _____________________________

ID#: ______________________________________ ID#: ____

GROUP #: _________________________________ GROUP #: ___________________________________

CO-PAY: __________________________________ CO-PAY: ____________________________________

SELF-PAY: Y / N

EMPLOYMENT HISTORY

EMPLOYED BY:____ LENGTH OF TIME:____________
ADDRESS: ________________________________CITY:_________________ST:________ZIP____________
POSITION:____
PREVIOUS JOB:____

EDUCATION

LAST GRADE COMPLETED:__________________ DIPLOMA/DEGREE:________________________
CERTIFICATION: ___________________________ LAST INST. ATTENDED:____________________

RELATIONSHIP STATUS

_____SINGLE/NEVER MARRIED _____ MARRIED DATE:____________ _______CO-HAB
_____SEPARATED _____ DIVORCED DATE:____________ _______WIDOWED

SPOUSE′S NAME:____ DOB:________________

ADDRESS: ____________________________________ PHONE (HOME):____________________
____________________________________ (WORK):____________________
____________________________________ (CELL): ____________________

EMPLOYED BY: ______________________________ HOW LONG? ____________________

PREVIOUS JOB:

____

IF DIVORCED, PLEASE GIVE PREVIOUS MARITAL HISTORY (NAME OF FORMER SPOUSE(S), YEARS MARRIED, DATE DIVORCED, CURRENT LOCATION, DEGREE OF CONTACT:

____
____
____

CHILDREN

NAME	DOB	GENDER(M/F)	LIVING(Y/N)	MARITAL STATUS

PRESENTING PROBLEM

BRIEFLY EXPLAIN WHAT BRINGS YOU IN FOR COUNSELING:

____
____
____

COUNSELING HISTORY

ARE YOU PRESENTLY SEEING A COUNSELOR? YES_____ NO_____

HAVE YOU HAD COUNSELING BEFORE? YES_____ NO_____

LIST THERAPISTS AND DATES:

____
____
____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC PROBLEMS? YES_____ NO_____

ARE YOU WILLING TO SIGN A RELEASE OF INFORMATION FORM SO THAT YOUR COUNSELOR MAY REQUEST REPORTS FROM PREVIOUS MENTAL HEALTH SERVICES/FACILITIES? YES_____ NO_____

HAVE YOU RECENTLY SUFFERED A SIGNIFICANT LOSS? YES_____ NO_____
EXPLAIN____
____
____

IS THERE ANY OTHER PERTINENT INFORMATION YOU WOULD LIKE TO PROVIDE?
____
____
____
____

Client Signature:_______________________________________ Date:____________________