

Halsey Counseling and Educational Center

330 East Coffee Street

Greenville, SC 29601

Phone: 864-527-5910 Fax: 864-527-5912

Client Intake

CLIENT: _____ SSN: _____

ADDRESS: _____

LIST STREET ADDRESS AND MAILING ADDRESS, IF DIFFERENT

TELEPHONE: HOME: _____ CELL: _____

WORK: _____

NO CALLS TO HOME

NO CALLS TO WORK

BIRTH DATE: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

CONTACT IN CASE OF EMERGENCY: _____

ADDRESS AND PHONE NUMBER OF CONTACT: _____

MEMBERS OF CURRENT HOUSEHOLD (LIST AGE AND RELATIONSHIP TO YOU):

_____	_____
_____	_____
_____	_____

EDUCATION: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

(CIRCLE HIGHEST GRADE LEVEL ATTAINED)

DEGREE(S): _____ CURRENT SCHOOL: _____

EMPLOYER: _____

NAME AND ADDRESS

OCCUPATION: _____

HOW WERE YOU REFERRED TO HALSEY COUNSELING AND EDUCATIONAL CENTER? _____

MAY WE ACKNOWLEDGE THE REFERRAL? YES NO

PLEASE GIVE A BRIEF DESCRIPTION OF YOUR CURRENT SITUATION/REASON FOR APPLYING FOR SERVICES AT HALSEY COUNSELING AND EDUCATIONAL CENTER:

PRIOR MENTAL HEALTH SERVICES: YES NO

(IF YES, PLEASE GIVE A BRIEF DESCRIPTION OF PROBLEM, WHO YOU SAW, AND WHEN.)

PRESENT PHYSICIAN: _____ DATE OF LAST PHYSICAL _____

Have you ever had any of the following?

	YES	NO	NOT SURE		YES	NO	NOT SURE
Frequent headaches	_____	_____	_____	Gallbladder disease	_____	_____	_____
Seizures/convulsions	_____	_____	_____	Recurrent vomiting/diarrhea	_____	_____	_____
Loss of consciousness	_____	_____	_____	Other intestinal problems	_____	_____	_____
Fainting spells	_____	_____	_____	Kidney or bladder disease	_____	_____	_____
Impaired vision	_____	_____	_____	Thyroid disease	_____	_____	_____
Impaired hearing	_____	_____	_____	Diabetes	_____	_____	_____
Arthritis	_____	_____	_____	Drug/Alcohol Dependence	_____	_____	_____
Heart disease	_____	_____	_____	Hepatitis	_____	_____	_____
High/low blood pressure	_____	_____	_____	Gonorrhea, syphilis or AIDS	_____	_____	_____
Chest pain	_____	_____	_____	Exposure infectious diseases	_____	_____	_____
Mitral valve prolapse	_____	_____	_____	Exposure to toxic chemicals	_____	_____	_____
Autoimmune illnesses	_____	_____	_____				
Asthma/ Allergies	_____	_____	_____				

Current Health Problems: _____

Current medications: _____

Prescribed by: _____

Drug allergies: (Drug name and type of reaction) _____

Operations: _____

Hospitalizations (Type, where, when): _____

Have members of your family ever had any of the following problems?
(Please refer to parents, grandparents, brothers, sisters and children)

	YES	NO	NOT SURE		YES	NO	NOT SURE
Mental retardation	_____	_____	_____	Hepatitis	_____	_____	_____
Learning disability	_____	_____	_____	AIDS	_____	_____	_____
Manic depression	_____	_____	_____	Diabetes	_____	_____	_____
Depression	_____	_____	_____	Thyroid disease	_____	_____	_____
Anxiety	_____	_____	_____	Heart disease	_____	_____	_____
Schizophrenia	_____	_____	_____	Dementia/Alzheimer's	_____	_____	_____
Drug or alcohol abuse	_____	_____	_____	ADHD	_____	_____	_____
Suicidal attempt	_____	_____	_____	Kidney disease	_____	_____	_____
Completed suicide	_____	_____	_____	Gastrointestinal disease	_____	_____	_____
Cancer	_____	_____	_____	Epilepsy /seizures	_____	_____	_____
Allergies/Asthma	_____	_____	_____	Migraine headache	_____	_____	_____

If client is a child, please complete:

	YES	NO	NOT SURE
Complications during pregnancy	_____	_____	_____
Drug or alcohol use during pregnancy	_____	_____	_____
Complications during delivery	_____	_____	_____
Sit, crawl, and walk at right times	_____	_____	_____
Problems with bowel and bladder training	_____	_____	_____
Problems with speech and language development	_____	_____	_____
Problems learning social skills	_____	_____	_____
Is there tension in the household	_____	_____	_____

Client/ Halsey Counseling and Educational Center Service Agreement

Please read carefully.

- ◆ A cornerstone of therapy is respect for confidentiality. All therapists are bound by the same confidentiality laws and by the ethical standards of their respective professions. Therapists are permitted to disclose information in the following situations:
 - A) Client requests therapist to disclose
 - B) Therapist determines client may be a danger to self or others
 - C) Therapist is ordered by the court or some legal proceedings
 - D) Therapist suspects child or elder abuse or neglect
 - E) In order to defend themselves against accusations of wrongful conduct.
 - F) For Worker's Compensation and similar benefit programs
- ◆ Halsey Counseling and Educational Center does not file claims with insurance companies.
- ◆ Payment is expected at the conclusion of each session. You will be charged for any scheduled appointments you fail to keep unless you give 24 hours notice of cancellation.
- ◆ Insurance information: If you wish to file for reimbursement on your own, the superbill you receive as a receipt may be attached to a completed claim form and you may mail it to your claims office. The diagnosis will be listed on the superbill provided. Any diagnosis will become a part of your permanent record.
- ◆ Halsey Counseling and Educational Center does not use electronic messaging such as email or text messages.
- ◆ If there is no direct contact between the client and Halsey Counseling and Educational Center for ninety (90) calendar days, the case is considered closed.

South Carolina provides the client opportunity to file inquiries with the Licensing Board of the respective professional (Psychologists, Licensed Social Workers and Licensed Professional Counselors):

SC Board of Examiners
PO Box 11329
Columbia SC 29211-1329

I have read the Application and Services Agreement. I fully understand and agree with its provisions. I specifically agree to accept full responsibility for payment of my account.

I have been sufficiently advised and give my informed consent to engage in psychotherapy, medical treatment, psychological assessment, psychoeducational evaluation, and/or related mental health services with Gloria Hash Marcus.

Client Name: _____

Date: _____
Signature

In my capacity as Personal Representative, I have been sufficiently advised and give my informed consent to participate in the psychotherapy, medical treatment, psychological assessment, psychoeducational evaluation, and/or related mental health services of the above-named client.

Date: _____
Signature

Date: _____
Signature