SAFEHAVEN
COUNSELING CENTER

Introductory Information Form

Please complete this form thoroughly. It will help us serve you efficiently and better understand your needs.

CLIENT			
Name:		Date of Birth:	Age:
Address:	City:	State:	Zip Code:
Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No		Alt. Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No	
Email:		OK to use email for communication? ☐ Yes ☐ No OK to email info on upcoming seminars? ☐ Yes ☐ No	
Social Security #:		Place of Employment:	

GUARDIAN (Required if filling out for a minor)			
Name:		Relationship to Clients:	
Address:	City:	State:	Zip Code:
Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No		Alt. Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No	
Email:		OK to use email for communication? ☐ Yes ☐ No OK to email info on upcoming seminars? ☐ Yes ☐ No	

RESPONSIBLE PARTY			
Name:		Date of Birth:	Age:
Address:	City:	State:	Zip Code:
Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No		Alt. Phone #: ☐ Cell ☐ Home ☐ Work Ok to leave message? ☐ Yes ☐ No	
Email:		OK to use email for communication? ☐ Yes ☐ No OK to email info on upcoming seminars? ☐ Yes ☐ No	
Social Security #:		Place of Employment:	

INSURANCE COMPANY (We are not Medicare or Medicaid participants)	
Company Name:	Company Phone #:
Policy #:	Group #:
Policy Holder's Name:	Policy Holder's Social Security #:
Are you hoping to use **E**mployee **A**ssistance **P**rogram benefits? ☐ Yes ☐ No *not all providers are EAP participants	
If yes to above, what is the name of your EAP? Have you preauthorized the EAP visits? ☐ Yes ☐ No	

GENERAL INFORMATION		
Is this a Crime Victims case? ☐ Yes ☐ No If yes; case #		
How did you find out about the SafeHaven Counseling Center?		
What are the main concerns which prompted you to seek help?		
What do you hope to accomplish from receiving psychotherapy services?		
Has the client or any family member received previous counseling or psychiatric services? If yes, please describe:		
Client's Medical Doctor:	Date last seen:	
Date of last physical:	Results:	
Is the client or any family member taking prescription medications? If yes, please fill out below.		
Name of person taking medication:		
RX name:	Dosage:	Date began:
RX name:	Dosage:	Date began:
Name of person taking medication:		
RX name:	Dosage:	Date began:
RX name:	Dosage:	Date began:
Does the client or any family member have any medical problems? If yes, please describe:		

Please describe, if any, the alcohol and drug use of the client over the last 12 months:
Is there any history of drug and/or alcohol treatment on behalf of the client? If yes, please describe:
Would you like biblical-based counseling to be incorporated into your services? If yes, please describe:

People currently living in your household

Name:	Relationship	Age	Grade/Occupation