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							
Seizures/convulsions				Gallbladder disease			
Loss of consciousness				Recurrent vomiting/diarrhea			
Fainting spells				Other intestinal problems			
Impaired vision				Kidney or bladder disease			
Impaired hearing				Thyroid disease			
Arthritis				Diabetes			
Heart disease				Drug/Alcohol Dependence			
High/low blood pressure				Hepatitis			
Chest pain				Gonorrhea, syphilis or AIDS			
Mitral valve prolapse				Exposure infectious diseases			
Autoimmune illnesses				Exposure to toxic chemicals			
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