Glen Haven Counseling Resources

Dr. Matthew Cooper, Dr. Daniel Earle

Client Name:_____ Today's Date:_____

Address:_____ City/ZIP:_____

Phone: (Home):_____ (Work):_____ (Cell):_____

Birthdate:_____ Age:_____ Social Security Number:_____

Marital Status: Single__ Married__ Divorced__ Separated__ Widowed__ How Long?___ # of Prev.Marr.__
Employer:_____ Your Title:_____
Employer Address:_____ How Long Employed There?_____
Education: Highest grade completed_____ Name of School:_____
Major area of study_____ Spouse Education:_____

Person Responsible for Payment or Insurance Coverage:_____
Relationship (if other than self):_____ Employer:_____
Birthdate:_____ Phone: (Home):_____ (Work):_____
Address:_____ City/State/Zip:_____
Social Security#/ID#:_____ Insurance Carrier:_____
Insurance ID#:_____ Insurance Group #:_____
Phone number for mental health benefits on the back of your insurance card:_____

Closest Relative Not Living With You: (Name)_____ (Relationship)_____
(Address)_____

All Those Living In The Same Household With You:

(Name)	(Age)	(Relationship)

Children Not Currently Living in Your Household:

(Name)	(Age)	(Relationship)

Family of Origin History:

Mother (age if living:__) (age at death, if deceased:__) Pertinent information about her:_____

Father (age if living:__) (age at death, if deceased:__) Pertinent information about him:_____

Siblings (names, ages, information):_____

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Do you have a family physician? If so, list name and city/town:_____

Are you currently taking any medication? If so, what kind(s), what dosage(s), and for what specific condition(s)?:_____

Have you been in therapy or received any professional assistance for your problem(s)? If so, who was your therapist and when did you see him/her?_____

Have you ever been hospitalized for psychiatric or psychological problems? If so, when and where?_____

_____

Does any member of your family suffer from an "emotional" or "mental" condition? If so, please specify person and condition:_____

Are there any medical or physical conditions that might affect the course of your therapy here? If so, indicate the nature of such:_____

Do you have a religious affiliation?_____

Where do you attend?_____

Who referred you to this office?_____

List the major events that have taken place in your life during the past three years (i.e., births, deaths, accidents, moves, children leaving home, etc.):_____

_____

_____

Are you here to address any issues or memories of abuse? Please be specific:_____

_____

What specific problems or difficulties are you here to discuss?_____

_____

_____

Check anything else below that may have contributed to your reason for seeking help at this time:

__ Feelings over a death
__ Alcohol or Substance Abuse
__ Another's Substance Abuse
__ Spiritual Concerns
__ Depression, Crying Spells
__ Stress or Anxiety
__ Family Problems
__ Relationship Problems
__ Inability to Concentrate
__ Eating Behavior
__ Sleeping Disturbances
__ Financial Concerns
__ Suicidal Thoughts
__ Academic Problems
__ Work Related Problems
__ Suggested by Someone
__ A Sexual Experience
__ Other:_____

Please list any other significant events that have taken place in your life that you might like to discuss with the counselor:_____

_____

_____