

## Glen Haven Counseling Resources

Dr. Matthew Cooper, Dr. Daniel Earle, Resa Eckhart, LMFT

Client Name:		Today's Date:	
Address:		City/ZIP:	
Phone: (Home):	(Work):	(Cell):	
Birthdate: Age:	Social Se	curity Number:	
Marital Status: Single Married D	ivorced Sepa	rated 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:	
	_		
<u>-</u>		ge:	
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 bene	efits on the back	of your insurance card:	
Closest Relative Not Living With You: (Name)		(Relationship)	
	(Address)		
All Those Living In The Same Househo	old With You:		
(Name) (Age)		(Relationship)	
Children Not Currently Living in Your	r Household:		
(Name)	(Age)	(Relationship)	
(2132110)	(90)	(-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	
Family of Origin History:			
, , ,			
Mother (age if living:) (age at deat	h, if deceased:_	) Pertinent information about her:	
Father (age if living: ) (age at death	if deceased:	Pertinent information about him:	
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Siblings (names, ages, information):_			

fax: 515-225-1744

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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  Relationship Problems  Another's Substance Abuse  Bairing Behavior  Suggested Problems  Spiritual Concerns  Eating Behavior  Suggested by Someone  Depression, Crying Spells  Stress or Anxiety  Financial Concerns  Other:  Please list any other significant events that have taken place in your life that you might like to discuss with the counselor:	Do you have a family physician? If so,	list name and city/town:				
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