Glen Haven Counseling Resources

Dr. Daniel Earle

Client Name:_____ Date:_____

Address:_____ City/Zip:_____

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

Birthdate:_____ Age:_____ E-mail Address:_____

Marital Status: Single__ Married__ Divorced__ Other__ How Long?__ Previous Marriages?__

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:_____ Cell#:_____ Work#:_____

Address:_____ City/State/Zip:_____

Insurance Carrier:_____ Insurance Plan:_____

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:_____

_____

_____

_____

_____