

## Glen Haven Counseling Resources

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

Client Name:		_Today's Date:			
Address:		City/ZIP:			
Phone: (Home):	(Work):	(Cell):			
Birthdate:	irthdate: Age: Social Security Number:				
	ed Divorced Separ	ated Widowed How Long? # of Prev.Marr Your Title:			
Employer Address:		How Long Employed There?			
Education: Highest grade com		Name of School:			
• •	/	Spouse Education:			
major area or study	<b>/</b>	opouse nadeation.			
Person Responsible for Payme	ent or Insurance Coverac	ge:			
Relationship (if other than self):					
<u> </u>		Employer: (Work):			
7 ddrogg,					
		City/State/Zip:			
Social Security#/ID#:		Insurance Carrier.			
Insurance ID#:Phone number for mental health benefits on the back of		Insurance Group #:			
I none number for memar near	in benefits on the back (	n your mourance cara.			
Closest Relative Not Living Wi	th You: (Name)	(Relationship)			
Closest Relative Not hiving Wi		(Netationship)			
	(Naaress)				
All Those Living In The Same I	Journald With You				
(Name)		(Relationship)			
(Name)	(Age)	(Netationship)			
Children Not Currently Living	in Vour Household.				
Children Not Currently Living		(Beletienship)			
(Name)	(Age)	(Relationship)			
-		_			
-		_			
Family of Origin History:					
,g,-					
Mother (age if living:) (age	at death, if deceased:	Pertinent information about her:			
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ratner (age if living:) (age a	it death, if deceased:)	Pertinent information about him:			
Ciblings (name: and info	ntiam).				
aiblings (names, ages, informa	anon):				

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:	
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.):  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  Femily Problems  Alcohol or Substance Abuse  Inability to Concentrate  Work Related Problems  Spiritual Concerns  Eating Behavior  Suggested by Someone  Depression, Crying Spells  Sleeping Disturbances  Stress or Anxiety  Please list any other significant events that have taken place in your life that you might like to discuss with the		• • • • • • • • • • • • • • • • • • • •	-
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