



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: _____ 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): _____

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:

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

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