Client Intake Form

A Window of Hope Counseling Center/- Harold W. Anderson LLC

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Harold W. Anderson, Ph.D., LMFT, CAC III, AAMFT Approved Supervisor

Client Name

Date (mm/dd/yyyy)

Street Address 1

Street Address 2 (Optional)

City

State

Zip Code

Email

Spouse Email

Main Phone

Mobile Phone (if different)

Work Phone (optional)

FAX (optional)

Birthday (mm/dd/yyyy)

Marital Status

Sex

What is your ethnicity?

Do you think ethnic or cultural issues will impact your treatment?

YES

NO

What is your sexual orientation?

What is your gender identity?

Female

Male

Transgender

Gender Fluid

On a scale of 1 to 10, 1 being no affect and 10 being maximal affect, how does your sexual orientation and/or gender identity affect your presenting problem?

	1	2	3	4	5	6	7	8	9	10

Explain:

Presenting Issue:

Presenting Issue (why you are seeking help; describe symptoms, frequency, progression, and situations in which it is most present):

When did you first experience this issue, and if more than three months, why did you wait so long?

What do you hope to accomplish with therapy? Be as specific as you can.

On a scale of 1 - 10, with 1 being no problem and 10 being maximal problem, how problematic is the presenting issue to your life?

	1	2	3	4	5	6	7	8	9	10

What have you done to try and alleviate this problem? Have you been able to alleviate this problem in the past? How?

Insurance Information

***We do not accept Anthem/Blue Cross, Blue Shield Insurance*. If we cannot accept your insurance or if you have no insurance, we will work on a slide scale fee based upon income.**

Name of Insurance Provider (bring insurance card to intake)

Group Number

Policy Name (e.g., Open Access Plus)

Member ID Number

Name of Employer

Copay (primary care)

Member Name

Policy Owner Name (if different)

Policy Owner Birthday (mm/dd/yyyy)

Amount of Deductible

Has deductible been met?

Family Information:

Spouse/Partner's Name

Birthday (mm/dd/yyyy)

Phone Number

Emergency Contact Person

Emergency Contact Person Phone

Oldest Child's Name

Birthday (mm/dd/yyyy)

Living at home?

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

Child's Name Birthday (mm/dd/yyyy) Living at home?

Child's Name Birthday (mm/dd/yyyy) Living at home?

Are there other family members living with you (list below along with relation)?

Family of Origin History

Where were you born ? Marital status of parents

Number of Brothers Brother's ages Number of Sisters Sister's ages

Please fill out the following questions about deceased family members.

Are any siblings deceased? How old were you at the time? What was the cause of death? Did you receive grief counseling?

If yes, from whom?

Is your father deceased? How old were you at the time? What was the cause of death? Did you receive grief counseling?

If yes, from whom?

Is your mother deceased? How old were you at the time? What was the cause of death? Did you receive grief counseling?

If yes, from whom?

Do or did any of your family members have (check all that apply):

A drinking problem | Drug Problem | Depression | If so, who?

Do or did any of your family members have (check all that apply):

Mood swings (depression with highs and lows) | Mental illness | Anxiety | If so, who?

Check any of the following that applied during your childhood or adolescence:

Happy Childhood	Family Problems	Drug Abuse
Unhappy Childhood	Alcohol Abuse	School Problems
Emotional Problems	Sexual Abuse	Behavioral Problems
Eating Disorder	Legal Trouble	Medical Problems

Other (please specify):

Who were you raised by?

If Legal Guardian, who?

What were the prevailing emotional overtones in your family when you were growing up?

What are the strengths that have helped you cope with problems in the past?

Violence History

Have you had any history of violent behavior?

YES

NO

If YES, please elaborate:

Psycho-Social History

Level of education (check the one(s) that apply

Less than high school

GED

Graduate High School

Technical School

Associate's Degree

Bachelor's Degree

Master's Degree

Doctorate

Post-doctoral work

Have you ever served in the Armed Forces?

YES

NO

If yes, does your military service affect your presenting problem

YES

NO

If YES, please explain:

Do you now or have you ever belonged to a group or social organization?

YES

NO

If yes, please list them below:

Do any of these groups or social organizations have an impact upon your presenting problem? Explain

Do you belong to a religious organization?

YES

NO

If YES, which religious organization?

Does your involvement in this religious organization impact your presenting problem? If so, explain below:

Medical Information:

Who is your primary care provider (PCP)?

Name, address, phone, FAX and Email of you PCP's practice?

When was your last physical?

If you are filling this out for a child, when was the last well-child exam or Early and Periodic Screening, Diagnostic, Treatment (EPSDT) exam?

If you have not had an exam in the last year, it is strongly recommended you do so before or soon after the beginning of mental health treatment

- Yes, I will schedule an exam as soon as possible.
- I do not wish to schedule an exam at this time.

Do you use tobacco products?

- YES
- NO

If yes, what kind (check all that apply)

- Cigarettes
- Cigars
- Vap
- Chewing Tobacco

If yes, how much do you use?

When did you begin smoking?

Have you ever tried to quit?

- YES
- NO

How many times have you tried to quit? What made you start again?

Signature Page

The information contained in this form is accurate to the best of my knowledge.

Signature

Date (mm\dd\yyyy)

Please return this form to the office at least 24 hours prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.