New Client Intake

191 Howard St., Suite 104, Franklin, PA 16323 • 814-312-0471

Renewed Hope Counseling

DATE: _____

Client's Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ □ May leave general message □ May leave private message

Cell Phone: _____ □ May leave general message □ May leave private message

Email: _____ Send reminders via: □ Phone/Cell message □ Email □ Text

Occupation(s): _____

Employer Name: _____

Marital Status: _____ Children: (YES or NO) Religious/Spiritual Affiliation, if any: _____

Emergency Contact Name: _____

Relationship: _____ Address: _____

Phone Number(s): Home _____Cell _____Other_____

If a Minor, Parent/Guardian's Name(s) _____

School Name _____Grade: _____

Other Parent: _____ Do they consent to counseling? (YES or NO)

Spouse's Name: _____

□ Private Pay □ Medicare □ Medicaid

Primary Insurance Company: _____

□ Employee Assistance Program _____ Authorization No. _____ Session# _____

□ Policy Holder: _____ D.O.B._____

Relationship to client: _____ □ MAID #_____

Member/Provider ID #: _____ Deductible: _____ Co-Pay: _____

Insurance #2: (if applicable) _____

□ Policy Holder: _____ D.O.B._____

Relationship to client: _____ □ MAID #_____

Member/Provider ID #: _____ Deductible: _____ Co-Pay: _____

New Client Intake (contin.)

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Date: _____

Client's Name: _____ Date of Birth: _____

Court Ordered? (YES or NO) If so by whom? _____

Attorneys Involved: _____

Name of Probation Officer/Agencies involved and contact info:_____

_____

Have you previously had counseling/therapy?

With whom When Type Outcome Why discontinued

_____

_____

List all medications you are currently taking:_____

Name of Primary Care Physician:_____

Would you like me to contact your doctor to coordinate care? □ Yes □ No □ If needed *Initials:* _____

Briefly describe your primary reason for seeking counseling today:

_____

List any other concerns in order of importance:

_____

How would you rate the effect of this issue on your daily life? (0=no effect, 10=extremely disruptive):

0 1 2 3 4 5 6 7 8 9 10 When did it begin? _____

Since the onset, has your primary problem: □ Improved □ Worsened □ Stayed the same □ Varied

Is it interfering with: □ Work □ Sports/Hobbies □ Sleep □ Intimate Relationship □ Social Interactions

□ Caring for yourself or others □ Health □ Energy □ Mood □ Mental focus □ Appetite

How would you rate your health in general? (0=Unhealthy, 10=Optimum Health): 0 1 2 3 4 5 6 7 8 9 10

What medical conditions are you currently or previously been treated for?

_____

_____