INTAKE FORM

Ken Haney MA, LPC
Licensed Professional Counselor #74222
4037 S.W. 50th Suite 115
806-236-1832

PERSONAL INFORMATION

CLIENT(S) NAME: _____
First, MI, Last

ADDRESS: _____
Street

_____
City State Zip

PRIMARY PHONE: (_____) _____

PRIMARY EMAIL: _____

Birthdate: _____

Age: _____

Race: _____

Birth State: _____

Marital Status: _____

Last grade attended/degree completed: _____

Employer: _____

Length of Employment: _____

Occupation: _____

Gross income: _____

SPOUSAL or PARENTAL INFORMATION

(Skip if not relevant to therapy. Give this information if spouse/parent is primary on insurance.)

Spouse/parent name: _____
Birthdate: _____

Occupation: _____
Spouse's employer: _____
Spouse's gross income: _____

Wedding date: _____
Either been divorced? _____
If so, who? _____

GENERAL INFORMATION

Names of persons with whom you are now living and their relationship to you (include ages of children):

NAME	AGE	RELATIONSHIP to CLIENT

Emergency Contact: _____

Phone: _____

Address: _____
Street

_____
City State Zip

Relationship to you: _____

State in your words, your reasons for seeking therapy (presenting issue):

When did the present problem start?

Circle how would you describe the severity of your concern in regards to the presenting issue:

MILDLY UPSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Have you attended therapy/counseling before? YES or NO

If yes, how many sessions? _____

Circle the type of therapy/counseling you received:

CLINICAL PSYCHOTHERAPY	PASTORAL COUNSELING	ENRICHMENT THERAPY	OTHER

How satisfied where you with the therapy/counseling you received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

What else, if anything, have you tried to correct the problem?

In your estimation, circle how interested in counseling you are now:

SOMEWHAT	MODERATELY	VERY INTERESTED

Please list the medications you are taking:

_____
_____
_____
_____

Have you ever been diagnosed with a mental illness? Yes/No. If yes, please specify which.

_____
_____
_____

Have you ever been diagnosed with a depression? Yes/No.

Do you drink alcohol more than once a week? □ No □ Yes
How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____
Have you ever been diagnosed with or treated for an addiction? Y/N. If yes, please specify which:

_____
_____
_____

What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle, List Family Member

Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

Please give any other information that you feel is important in preparation for counseling:

What do you anticipate achieving? What is/are your goal(s)?

DUTY TO WARN/DUTY TO PROTECT

If my therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

PERSON TO BE CONTACTED	PHONE NUMBER	RELATIONSHIP

[ ] Initial—I understand that if I fail to cancel an appointment within 24 hours of the scheduled session I may be charged for the full amount of the session. I will do my best to inform the therapist as soon as possible if I realize that I will not be able to keep an appointment. Insurance cannot be billed for sessions that I don't keep. I will be responsible to pay the full amount.

[ ] Initial—I acknowledge that I am responsible to pay the portion of the fee that insurance does not cover. This amount is limited to what is allowable based on the contract with the insurance provider as long as the policy is in effect. I acknowledge that I am responsible for knowing what my liability might be.

[ ] Initial—I consent to receive communication related to insurance and appointments via text or email from the counselor. I recognize that communication related to counseling issues might not be secure if sent electronically.

The Office of Ken Haney, M.A. LPC, is required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/ Electronic Protected Health Information). This notice is located on our website and in paper format with our informed consent. You may also receive a paper copy at no charge upon your request. If you have any objections to this notice, please ask to speak with or leave a message at 806.236-1832 for my HIPAA/ HITECH Certified Office Administrator.

[ ] Initial—I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practice Document.

[ ] Initial—I hereby give consent to Ken Haney Counseling to bill my insurance for the counseling sessions.

_____ _____/_____/_____

Signature of Client or Client's Consenting Adult (if under 18) Date

_____

Relationship of Consenting Adult