INTAKE FORM

Ken Haney MA, LPC-S
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: (Write Carefully) _____

Birthdate: _____

Age: _____

Race: _____

Marital Status: _____

Length of Employment: _____

Occupation: _____

Who is Primary on the Insurance? _____

Employer: _____

SPOUSAL or PARENTAL INFORMATION

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

Spouse/Parent Name:
_____

Birthdate: _____

Spouse's Phone Number:
_____

Have either been divorced? _____

Wedding Date: _____

If so, who? _____ _____

Spouse's Occupation

_____

Spouse's Employer: _____

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

NAME	AGE	RELATIONSHIP to CLIENT

DUTY TO WARN/DUTY TO PROTECT

[ ] Initial—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:

Emergency Contact:. _____

Phone: _____

Address: _____
Street

_____
City State Zip

Relationship to you: _____

If there is any abuse of a child, or an elderly person, or if there is a threat to someone's safety, the therapist is required to report it.

Counseling Questions

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 [ ]NO

If yes, how many sessions, as best you can recall? _____

Circle the type of therapy/counseling you received:

CLINICAL PSYCHOTHERAPY	PASTORAL COUNSELING	UNKOWN	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 that might affect your mood:

_____
_____
_____
_____

Have you ever been diagnosed with any of the following:

[ ] Depression? .
[ ] Anxiety?
[ ] Panic Attacks?
[ ] Bipolar Disorder 1 or 2
[ ] PTSD
[ ] Dissociative Identity Disorder?
[ ] Personality Disorder?
[ ] Schizophrenia

Have you ever experienced:

[ ] Trauma Mild/Severe
[ ] Sexual Abuse
[ ] Sexual Assault
[ ] Been the Victim of a Crime?

Do you drink alcohol more than once a week? □ No □ Yes
How often do you use recreational drugs?
[ ] 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? [ ] No [ ] Yes
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

Anxiety

Depression

Domestic Violence

Eating Disorders

Obesity

Obsessive Compulsive Behavior

Schizophrenia

Suicide Attempts

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)?

Understanding and Consents

[ ] 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 secure 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 (Ken Haney Counseling.Com) under "Forms" 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.

[ ] 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)

_____

Today's Date_____/_____/_____

Relationship of Consenting Adult_____

Headway Intake Form

Headway is a billing agency that will process your insurance claim and charge you for your deductible or copay if you owe one. It may also bill you for a no call/no show event if you fail to cancel an appointment.

If you fill out this form, Headway will send you a confirmation email, so that you can verify that you want to do this. If you don't respond to the email, you will not be able to use Headway.

You do not need to fill it out if you do not have one of the insurances listed at the bottom of the page.

PERSONAL INFORMATION

First Name (As it is on your insurance card: _____

Last Name: _____

Email address (write clearly) _____

Date of Birth: _____/_____/_____

INSURANCE INFORMATION

Insurance Company: _____

Member number: _____

Group Number: _____

CARD INFORMATION

Name on Card: _____

16 Digit Card Number: _____ _____ _____ _____

Expiration Date: _____

Security Code (from back of the card): _____

Billing Zip Code: _____

Insurances accepted by Headway:

- **Aetna**
- **Cigna**
- **Oxford**
- **United**
- **Oscar**
- **Blue Cross Blue Shield**