INTAKE INVENTORY

Date: _____ Counselor: **Don Bartley, D.Min, LMFT**

CLIENT INFORMATION

Name: _____ Gender: ☐ M ☐ F

Address: _____

City, State, Zip: _____

Home Phone: _____

Employer: _____

Bus. Phone: _____ Mobile_____

Date Of Birth: _____ Age: _____

☐ Married _____years. Date of Marriage: _____

☐ Remarried ☐ Divorced _____years ☐ Widowed ____

☐ Single ☐ Engaged ☐ Separated (How long?) _____

FAMILY / SPOUSE INFORMATION

☐ Spouse / ☐ Parent: _____

Address: _____

City, State, Zip _____

Home Phone: _____

Employer: _____

Bus. Phone: _____ Mobile_____

Date Of Birth: _____ Age: _____

☐ Married ____years

☐ Remarried ____ years ☐ Divorced _____years ☐ Widowed

☐ Single ☐ Engaged ☐ Separated (How long)_____

Education 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+ School _____

Other (list types and years) _____

Church where you attend: _____ Member ___Yes ___No

Information regarding children--

Name:	Age:	Gender:	Living:	School Grade:
_____	_____	☐ M ☐ F	☐ In Home ☐ Out of Home	_____
_____	_____	☐ M ☐ F	☐ In Home ☐ Out of Home	_____
_____	_____	☐ M ☐ F	☐ In Home ☐ Out of Home	_____
_____	_____	☐ M ☐ F	☐ In Home ☐ Out of Home	_____
_____	_____	☐ M ☐ F	☐ In Home ☐ Out of Home	_____

PARENTAL CONSENT

MUST BE COMPLETED FOR ALL CLIENTS UNDER THE AGE OF 18.

I, as legal guardian, give my authorization for Dr. Don Bartley to counsel with the above-mentioned minor.

Signature _____ Date _____

HEALTH

How would you rate your physical health? ☐ Very Good ☐ Good ☐ Average ☐ Poor

List medication:	For what condition?	Med. Dr._____
_____	_____	Referring Dr._____
_____	_____	Other health info/concerns:
_____	_____	_____
_____	_____	_____
_____	_____	_____

COUNSELING DATA

How did you hear about Dr. Bartley? Phone Book: ☐ Embarq ☐ Randolph County ☐ Randolph Telephone

☐ Friend ☐ Family member ☐ Newspaper ☐ Pastor _____ ☐ Doctor ☐ Other _____

Have you ever been seen or treated by a psychiatrist, counselor, or therapist? ☐ Yes, How long? _____ ☐ No

Names of counselors and approximate dates of counseling _____

Please state in a few sentences the major counseling need you have at this time. _____

_____

_____

_____

ISSUES

Are any of the following issues a problem to you at this time? Check all that apply:

___Anger	___Rage	___Marriage Problems	___Relationship to Parents
___Grief	___Self Esteem	___Sexual Problems	___Relationship to Children
___Depression	___Substance Abuse	___Guilt Feelings	___Loss of Faith in God
___Nervousness	___Chronic Fear	___Loss of Hope	___Loss of Meaning of Life
___Loneliness	___Loss of Work/Job	___Suicidal Feelings	___Stress
___Anxiety	___Conflicts at work	___Religious Doubts	___Other_____

PAYMENT INFORMATION

Party responsible for payment <u>if other than client</u>:

Name _____

Address _____

_____

Phone _____

EAP information _____

_____

_____

Are you filing insurance claims? ___ Yes ___ No

MENTAL HEALTH BENEFITS INSURANCE INFORMATION

If you are requesting that I file the claims for you please complete the information below. **Please be advised that you are still financially responsible for the sessions whether your insurance company covers services rendered or not.**

Policyholder's Information

Name_____

Policyholder's Date of Birth _____

Employer_____

Address: _____

_____

Phone: _____

Employer: _____

Insurance Company Information:

Name of Ins Co. _____

Claims Mailing Add: _____

_____

_____

Ins Co Phone # _____

Subscriber # _____

Group #_____

Group Name _____

Is Dr. Bartley in or out of network? _____

Pre-Certification needed? ___Yes ___No

# of Visits Allowed Per Year_____

Amount Paid by Insurance_____

Co-pay/Co-Insurance Amt $_____

Deduct. Amt._____ Ded. Met?_____

Deductible Amount Remaining_____

When does deductible start over? _____

What Plan Covers: ☐ Individual ☐ Marital ☐ Family ☐ Group

I consent to treatment and attest that the information given is accurate to the best of my knowledge. I authorize the release of any medical information necessary to process insurance claims filed on my behalf or for coordination of benefits. I hereby assign payment of insurance benefits to Dr. Don Bartley, LMFT as he files the claims for me. I acknowledge that I am financially and legally responsible for the payment of services whether my health insurance covers services rendered or not.

Date: _____ Signature of client _____