Client ID: _____

Intake Form
Counselor: Hannah Houston, LCMHC

Client Information

Name: _____ Gender: ☐M ☐F
Phone: _____ ☐Home ☐Work ☐Cell
Phone 2: _____ ☐Home ☐Work ☐Cell
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Age: _____ Date of Birth: _____
Employer/Occupation: _____
Years and Level of Education: _____
Religion: _____
Do you attend church at this time? ☐Yes ☐No ☐Occasional
Marital Status: ☐Single ☐Married _____ years ☐Remarried ☐Divorced _____ years
☐Engaged ☐Separated _____ How long?

Family/Spouse Information

☐Spouse ☐Parent: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ ☐Home ☐Work ☐Cell
Phone 2: _____ ☐Home ☐Work ☐Cell
Email: _____
Age: _____ Date of Birth: _____
Employer/Occupation: _____
Marital Status: ☐Single ☐Married _____ years ☐Remarried ☐Divorced _____ years
☐Engaged ☐Separated _____ How long
Information Regarding Children:

Name:	Age:	Gender:	Living (In or out of home):	Grade:
_____	_____	☐M ☐F	_____	_____
_____	_____	☐M ☐F	_____	_____
_____	_____	☐M ☐F	_____	_____
_____	_____	☐M ☐F	_____	_____

Client ID: _____

PARENTAL CONSENT

Must be completed by all clients under the age of 18.

I, as legal guardian, give my authorization for Hannah Houston to counsel with the above-mentioned minor.

Signature: _____ Date: _____

Have you had prior experience in counseling? ☐Yes ☐No

If yes, please describe with whom, when, how long, and for what: _____
_____
_____
_____

Please describe the major counseling need you have at this time: _____
_____
_____
_____

Current/Recent Mood (general state lately):

___ Anxiety
___ Fear
___ Sadness
___ Grief
___ Anger
___ Irritability
___ Happy
___ Impatient
___ Calm
___ Numb
___ Depression
___ Nervousness
___ Loneliness
___ Rage
___ Self Esteem
___ Substance Abuse
___ Loss of Job/Unemployment
___ Conflicts at Work
___ Marriage Problems
___ Sexual Problems
___ Guilt
___ Hopelessness
___ Suicidal Feelings
___ Relationships with Family/Children
___ Stress
___ Loss of Meaning of Life
___ Religious Doubts

Client ID: _____

Any changes or concerns involving the following? (Please check those which apply)

___ Finances
___ Legal Matters
___ Work/Job
___ Education/School
___ Moving
___ Marital Status
___ Parenting
___ Concentration
___ Memory
___ Energy
___ Health/ Illness
___ Surgery/Injury
___ Grief/Loss
___ Addition of a Family Member
___ Family Member Leaving Home
___ Sexual Activity
___ Sleep Habits
___ Eating Habits
___ Caffeine Intake
___ Tobacco Use
___ Alcohol Use
___ Drug Use

Health:

Please identify any allergies, significant health problems, or surgeries you have had, or currently have: _____
_____
_____

Please name your current primary care physician: _____

Please list any current medications you are taking: _____
_____
_____

How did you hear about our office?

☐Website ☐Facebook/Social Media ☐Phone Book ☐Friend ☐Family Member ☐Pastor ☐Doctor ☐Other _____

Payment Information

Party Responsible for Payment if Other than Client:

Name: _____ Address: _____
Phone: _____
EAP Information: _____
Are you filing insurance claims? ☐Yes ☐No

Client ID: _____

Mental Health Benefits Insurance Information

If you are requesting that I file 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: _____ Address: _____

Policyholder's Date of Birth: _____ Phone: _____

Employer: _____

Insurance Company Information:

Name of Insurance Company: _____ Phone: _____

Subscriber #: _____ Group #: _____

Group Name: _____ Is Hannah Houston in or out of network? ☐In☐Out

Pre-Certification Needed? ☐Yes ☐No Number of visits per year: _____

Amount Paid by Insurance: _____ Co-Pay/Co-Insurance Information: _____

Deductible Amount: _____ Deductible Met: _____

When does deductible start over? _____

What plan covers: ☐Individual ☐Marital ☐Family ☐Group

I, _____, understand and agree to pay costs incurred, including my co-payment or those expenses not covered by my insurance, as agreed upon with the therapist during the initial session. I understand I am responsible for sessions not cancelled 24 hours in advance. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment, when necessary. Re: CONFIDENTIALITY: I understand that my sessions are confidential unless I sign a release, except for the above authorization to the insurance company. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply. My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Signature: _____ Date: _____

Please print name: _____ Witness: _____