Client Information & Intake Form

Dan Anderson, MA, LPC

Legal Name: _____ Today's Date: _____

Home Address: _____

City, State, Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Birthdate: _____

Gender: _____

Marital Status: _____

Names & ages of any children and their living arrangements:

_____
_____
_____
_____

Please describe any previous counseling, therapy or mental health treatment including dates & provider/treatment facility name(s):

_____
_____
_____
_____

Please identify any significant health problems:

_____
_____
_____
_____

List any medications and dosages:

_____
_____
_____
_____
_____
_____

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What brings you to counseling at this time? Include goals for counseling (if any):

_____
_____
_____
_____
_____
_____

Favorite activities:

_____
_____
_____
_____
_____

Do you exercise? _____

If yes, what types of exercise? How many times per week?

_____
_____
_____
_____

Describe your eating habits and diet:

_____
_____
_____
_____

Do you smoke? _____

Do you consume alcohol? _____

If yes, how many alcoholic beverages per week?

_____

Do you use non-prescribed (recreational) drugs?_____

If yes, what types of drugs and how often?

_____
_____
_____
_____

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Clients are required to pay Dan Anderson directly at the time of service. Client understands that if he/she is unable to make an appointment, client will cancel the appointment by telephone at least 24 hours in advance. If client misses an appointment without giving 24 hour notice by phone, client agrees to pay the full fee (fee is $200.00 per 50 minutes) before another appointment will be scheduled. Client understands that if client misses two appointments without 24 hour advance notice, that counseling will be discontinued for twelve months.

I have read and understand this form and agree to terms and conditions. I am consenting to counseling and releasing Dan Anderson, MA, LPC from any and all associated liability. I am personally responsible for payment and will pay in full at the time of each meeting. My signature below also confirms that I have received a copy of the “HIPAA Notice” and a “Professional Disclosure Statement” at our first meeting.

Printed Legal Name: _____ Date: _____

Signature: _____ Date: _____