

Client Information & Intake Form
Dan Anderson, MA, LPC

Please print this form, complete it and bring it to your first appointment. You will sign & date the form at our first meeting.

Legal Name: _____ Today's Date: _____

Home Address: _____

City, State, Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Birthdate: _____

☐

Male

☐

Female

Marital Status: _____

Names & ages of any children and their living arrangements: _____

Please describe any previous counseling, therapy or mental health treatment including dates & provider 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? ☐ Yes ☐ No
If yes, what types of exercise? How many times per week?

Describe your eating habits and diet:

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No
If yes, how many alcoholic beverages per week?

Do you use non-prescribed (recreational) drugs? ☐ Yes ☐ No
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 \$100.00 per 50 minutes).

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: _____

*Please print and bring all pages of the completed form to our first meeting.