SAFE HAVEN COUNSELING, LLC

Behavioral Health Services

145 S. Santa Claus Lane
North Pole, AK 99705
907-490-SAFE (7233)

CLIENT INTAKE FORM

Please provide the following information for our records. Information you provide is held in strict standards of confidentiality as required by state and federal law. PLEASE PRINT NEATLY.

Client Name: ____
(Last) (First) (Middle Initial)

Birthdate: _____/_____/_____ Age: _____ Gender: _____ SSN: ____________________________

Marital Status: ___________ Race (optional): ________________________________

Local Mailing Address: ____
PO Box or Street and Number, City, State, Zip

Street Address (if different from mailing address): ______________________________

Name of parent/guardian (if client is a minor):

____
(Last) (First) (Middle Initial)

Home/primary phone ______________________________ May we leave a message? _____

Cell/other phone ______________________________ May we leave a message? _____

Email address ____

* Preferred method of contact for appointment reminders (check one): ______ Email*# ______ Text*#

Emergency contact name: ______________________________________ Relationship: _____________

Contact number: _______________

Referred by: ____

Employer: ____

Primary Insurance: ____

Insurance Address: ____
Street and Number, City, State, Zip

Group Number: _______________ Insured's Identification/Benefits #: _______________________

Secondary Insurance: ____

Secondary Insurance Address: ____
Street and Number, City, State, Zip

Group Number: _______________ Insured's Identification/Benefits #: ______________________

Relationship of Insured to client: ____

I agree to the release of relevant information to my insurance carrier or other provider and to authorize payments to Safe Haven Counseling, LLC. This authorization is valid until I revoke it in writing.

____

Signature Date

*** While we try to provide reminders of upcoming appointments as a courtesy to our clients, for various reasons we are not always able to do so. Failure to receive or see a reminder from us does not absolve you of your responsibility to attend your scheduled appointments, provide a minimum 24-hour notice of cancellation, or request rescheduling as outlined in your Client Services Contract. Please note that if the therapist's caseload precludes rescheduling you will incur the Late Notice/No Notice No Show fee listed in the Client Services Contract.**

[#] Email and text reminders are unencrypted, meaning the information they contain may be visible by an unknown/unauthorized third party. Selecting this option indicates your knowledge and approval of these methods of communication. *We will only include appointment information in these formats and discourage you from using them to send any information you want kept confidential.* Your initials indicate you have fully read and understand this information. _________ (initial)

MEDICAL HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy? _____

If so, what is (are) the name(s) of the provider(s)? _____________________________________

____

Have you had previous psychiatric services, professional counseling, or psychotherapy? _____

If so, what is (are) the name(s) of the provider(s)? _____________________________________

____

Are you currently taking prescribed psychiatric medication? _____

If so, please list the medications: ____

____

If no, have you been previously prescribed psychiatric medications? _____

If so, please list: ____

____

HEALTH AND SOCIAL INFORMATION

How is your physical health at the present time? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): ____

Please list all medications and supplements that you are currently taking: _________________________

___________________ ____________________ ___________________ ________________________

___________________ ____________________ ___________________ ________________________

Are you currently having problems with your sleep? __________

If yes, which are applicable? (please circle)

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

Other:____

How many times per week do you exercise and for how long each time? _________________________

____

Are you having difficulty with appetite or eating habits? _____

If yes, which apply? (Please circle)

Eating less Eating more Binging Not eating

Have you experienced significant weight change (5% or more) in the last two months? _____

Do you regularly use alcohol? _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period? ___________________

How often do you engage in recreational drug use? (please circle)

Daily Weekly Monthly Rarely Never

Have you ever had substance abuse treatment? _____ If so, what date(s) and type(s) of treatment

____

Have you had any suicidal thoughts in the past 12 months? (please circle)

Frequently Sometimes Rarely Never

Have you had them prior to the past 12 months? (please circle)

Frequently Sometimes Rarely Never

Are you currently in a romantic relationship? _____

If yes, how long have you been in this relationship? ____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

Please describe any significant life changes or stressors occurring in the past year: __________________

____

Are you currently having any legal problems? _______ If so, please explain briefly _________________

____

Have you experienced:

Extreme depressed mood? _____

Wild mood swings? _____

Rapid speech? _____

Extreme anxiety? _____

Panic attacks? _____

Phobias? _____

Hallucinations? _____

Unexplained memory lapses? _____

Alcohol/substance abuse? _____

Frequent body complaints _____

Body image problems _____

Repetitive/uncontrollable & unwanted thoughts _____

Repetitive/uncontrollable & unwanted behaviors _____

Homicidal thoughts _____

Suicide attempt(s) _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family been diagnosed with or experienced difficulties with the following? (Please circle any that apply and list family members.)

Difficulty	**Family Member**
Depression	____
Bipolar Depression	____
Anxiety Disorders	____
Panic Attacks	____
Schizophrenia	____
Alcohol/Substance Abuse	____
Eating Disorders	____
Learning Disabilities	____
Trauma History	____
Suicide Attempts	____

____

Signature (Guardian's signature if you are a minor)   Date