A Window Hope Counseling Center / Harold W. Anderson LLC

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visit our website at www.HaroldAnderson.net

Harold W. Anderson, Ph.D., LMFT, CAC III, Certified Sandplay Therapist

Personal Information

First Name | Middle initial | Last Name

Street 1

Street 2

City

State | Zip | Email

Main Phone | Type of phone

Birth date (mm/dd/yyyy) | Marital Status | Sex

Name of Insurance Provider (show card upon intake)

Note: We do not accept Anthem Blue Cross Blue Shield Insurance

Name of Insured's Employer

Spouse/Partner Name | Spouse/Partner's Phone

Spouse/Partner's Birthday (mm/dd/yyyy)

Emergency Contact Person

Emergency Contact Phone

Child's name | Birthday (mm/dd/yyyy) | Living at home?

Child's name | Birthday (mm/dd/yyyy) | Ling at home?

Child's name | Birthday (mm/dd/yyyy) | Living at home?

Child's name | Birthday (mm/dd/yyyy) | Living at home?

Child's name | Birthday (mm/dd/yyyy) | Living at home?

Medication for Psychiatric Treatment

Have you ever taken any medication for psychiatric treatment?

- ◯ YES
- ◯ NO

If YES, please fill out the table below to the best of your knowledge:

Medication Name | Dose | How long? (months) | End Date

Therapeutic Effect | Side effects | Reason for stopping

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Therapeutic Effect | Side effects | Reason for stopping

Psychiatric Inpatient History

Do you have a history of inpatient psychiatric care?

- ◯ YES
- ◯ NO

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Hospital Facility | Treatment Voluntary | Primary Reason for Hospitalization | How old were you?

Treatment Outcome | Additional Comments

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Treatment Outcome | Additional Comments

Mental Health Care

Do you have a history of outpatient psychiatric treatment?

- ◯ YES
- ◯ NO

Provider | Reason for seeking treatment | Age of First Treatment | Age of Last Treatment

Treatment Outcome | Additional Comments

Provider | Reason for seeking treatment | Age of First Treatment | Age of Last Treatment

Treatment Outcome | Additional Comments

Provider | Reason for seeking treatment | Age of First Treatment | Age of Last Treatment

Treatment Outcome | Additional Comments

Suicide/Self-Harm History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever tried to harm or kill yourself? If you answered "no," skip the rest of this section

- ◯ YES
- ◯ NO

Was your intent to die? Elaborate if desired

- ◯ YES
- ◯ NO

Medical History

Primary Care Provider | Phone | Date of last physical exam

Do you have a history of any of the following? (check all that apply)

- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hypertension/High Blood Pressure
- ☐ High Blood Sugar/Diabetes
- ☐ Heart Disease
- ☐ Cancer
- ☐ Insomnia
- ☐ Eating Disorders
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Fatigue/Lethargy
- ☐ Muscle pain or cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Back pain or stiffness
- ☐ Chronic Illness
- ☐ Chronic Pain

Other (explain below

What is the issue that brings you to the clinic today?

How may we contact you? (check all that apply)

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ Email
- ☐ Leave message on answering machine
- ☐ Mail

By Checking the box below I verify that all answers are true to the best of my knowledge

- ☐ I agree that verything herein is accurate to the best of my knowledge.

Signed

Date (mm/dd/yyyy)

Signed

Date (mm/dd/yyyy)

Please return this form to the office one day prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-867-0524. If you choose to email it you can go to Sendinc at www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.