Patient Intake Form

A Window of Hope Counseling Center/-
Harold W. Anderson LLC

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Harold W. Anderson, Ph.D., LMFT, CAC III, AAMFT Approved Supervisor

Patient Code (Office Only):

Date (MM\DD\YYYY)

Street Address 1:

Street Address 2:

City:

State:

Zip

EmailL

Spouse/Partner Email:

Main Phone:

Mobile Phone (if different):

Work Phone (optional)

FAX (optional)

Birthday (MM\DD\YYYY)

Did you serve in the military?

- ◯ YES
- ◯ NO

Type of discharge?

Type of discharge?

Insurance Information:

We do not accept Anthem/Blue Cross, Blue Shield Insurance. If we cannot accept your insurance or if you have no insurance, we will work on a slide scale fee based upon income.

Name of Insurance Provider (bring insurance card to intake)

Group Number

Policy Name (e.g., Open Access Plus)

Member ID Number

Name of Employer

Copay (primary care)

Member Name

Policy Owner Name (if different)

Policy Owner Birthday (mm/dd/yyyy)

Amount of Deductible

Has deductible been met?

- ◯ YES
- ◯ NO

Do you have a second insurance policy?

- ◯ YES
- ◯ NO

If so, list name of insurance company, policy number, etc.
Please present your insurance card at intake.

Family Information:

Spouse/Partner's Name

Birthday (mm/dd/yyyy)

Phone

Emergency Contact Person (if other than spouse/partner)

Emergency Contact Person

Oldest Child's Name

Birthday (mm/dd/yyyy)

Living at home?

- ◯ YES
- ◯ NO

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

- ◯ YES
- ◯ NO

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

◯ YES
◯ NO

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

◯ YES
◯ NO

Child's Name

Birthday (mm/dd/yyyy)

Living at home?

◯ YES
◯ NO

Are there other family members living with you (list below along with relation)?

What is you combined annual income? **(mandatory for Medicaid)**

◯ I prefer not to say.

Family of Origin History

Hispanic Ethnicity

Race

Where were you born ?

Marital status of parents

◯ Married
◯ Divorced
◯ Separated
◯ Widowed

Number of Brothers (list names)

Brother's ages (in order of list)

Number of Sisters (list names)

Sisters' ages (in order of list)

Please fill out the following questions about deceased family members.

Are any siblings deceased?

How old were you at the time?

What was the cause of death?

Did you receive grief counseling?

◯ YES
◯ NO

◯ YES
◯ NO

If yes, who?

Is your father deceased?

How old were you at the time?

What was the cause of death?

Did you receive grief counseling?

◯ YES
◯ NO

◯ YES
◯ NO

Is your mother deceased?

How old were you at the time?

What was the cause of death?

Did you receive grief counseling?

◯ YES
◯ NO

◯ YES
◯ NO

Do or did any of your family members have (check all that apply):

A drinking problem ☐

If so, who?

Drug Problem ☐

If so, who?

Depression ☐

If so, who?

Mood swings (depression with highs and lows) ☐

If so, who?

Mental illness ☐

If so, who?

Anxiety ☐

If so, who?

Check any of the following that applied during your childhood or adolescence:

- [ ] Happy Childhood
- [ ] Alcohol Abuse
- [ ] Drug Abuse
- [ ] Emotional Problems
- [ ] Sexual Abuse
- [ ] School Problems
- [ ] Eating Disorder
- [ ] Legal Trouble
- [ ] Behavioral
- [ ] Family Problems
- [ ] Unhappy Childhood
- [ ] Medical Problems

Other (please specify):

Who were you raised by?

If Legal Guardian, who?:

What were the prevailing emotional overtones in your family when you were growing up?

What are the strengths that have helped you cope with problems in the past?

Violence History

Have you had any history of violent behavior?

- ◯ YES
- ◯ NO

If YES, please elaborate below:

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:

- [ ] None of these
- [ ] Exposure to drugs or alcohol during pregnancy
- [ ] A difficult pregnancy
- [ ] Problems with delivery

Other

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

- [ ] YES
- [ ] NO

Did you have any delays or difficulties in reaching the following developmental milestones?

- [ ] None of these
- [ ] Walking
- [ ] Talking
- [ ] Toilet training
- [ ] Sleeping alone
- [ ] Being away from parents
- [ ] Making friends

Other:

Which options below best describe your childhood home atmosphere?

- [ ] Normal
- [ ] Supportive
- [ ] Parental fighting
- [ ] Parental violence
- [ ] Financial difficulties
- [ ] Frequent moving

Other

Which of the following challenges were experienced during your childhood?

- [ ] None of these
- [ ] Tantrums
- [ ] Enuresis (bed wetting)
- [ ] Encopresis (fecal incontinence)
- [ ] Running away from home
- [ ] Fighting
- [ ] Stealing
- [ ] Property damage
- [ ] Fire setting
- [ ] Animal cruelty
- [ ] Separation anxiety
- [ ] Victim of bullying
- [ ] Engaged in bullying
- [ ] Depression
- [ ] Death of a parent/ caregiver
- [ ] Parental divorce

Other

Which of the following best describe problems you may have had in school?

- [ ] None of these
- [ ] Fighting
- [ ] School phobia
- [ ] Truancy
- [ ] Detentions
- [ ] Suspensions
- [ ] Expulsions
- [ ] School refusal
- [ ] Class failures
- [ ] Repetition of grades
- [ ] Special education
- [ ] Remedial classes

Other

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)

- [ ] None of these
- [ ] Speech classes
- [ ] Tutoring
- [ ] Accommodations

Other

If you have any further comments about your developmental or educational history and wish to elaborate further, please do so in the space provided below:

The information in this questionnaire is accurate to the best of my knowledge

Signed

Date (mm\dd\yyyy)

Please return this form to the office at least 24 hours prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.