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Today's Date: _____

Welcome to our practice! We're very pleased that you've chosen to entrust us with your care. In order to ensure that we have all the necessary information to contact you, please complete the following information. In the course of our work together, if any of this information changes, be sure to notify us. Thank you!

Intake Information

Full Legal Name of Client: _____

Age: _____ DOB: _____ Marital Status _____

Address/City/State/Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email _____

Is it ok to contact you, text, call and/or leave messages at the numbers and email above? _____

Emergency Contact Person: _____

Emergency Contact Phone #: _____

Employer & position: _____

Who referred you for counseling? _____

Doctor & Medicine Family Physician Name _____

Physician Phone and Group Name: _____

Psychiatrist Name (if app): _____

Psychiatrist Phone and Group Name: _____

List all medicines you are currently taking:

Mental Health History:

Previous counseling/psychiatric treatment? _____

Name of Therapist/psychiatrist/social worker: _____

Diagnosis: _____

Approximate dates of treatment: _____

Hospitalizations?: Date(s): _____

Hospital(s): _____

Circumstances: _____

Have you ever attempted suicide? _____

Are you currently having any suicidal thoughts? _____

Additional Information:

Do you currently use any of the following substances:

Alcohol (If yes, how much?) _____

Cigarettes (If yes, how much?) _____

Other chemical substances (marijuana, cocaine, etc) (If yes, how much?) _____

Caffeine(If yes, how much?) _____

How much sleep do you routinely get each night? _____

Do you have any sexual concerns? (If yes, please describe):

Insurance Information:

Insurance Company Name: _____

Insured's DOB: _____

Insured's name: _____

Insured's social security #: _____

If Patient is a Minor: Mother's name: _____

Mother's phone #: _____

Father's name: _____

Father's phone #: _____

