Erin Sanford, LPC-MH, NCC, QMHP
Jennifer Zerfas, LPC-MH, NCC, LAC, QMHP
Lindsey Waggoner, MA, LPC, NCC
Jenny Sanford- Office Manager
316 E. Holly Blvd. PO Box 41
Brandon, SD 57005

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):____

Hosptital(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 #:____

By my signature below I grant permission for Agapé Counseling Center to bill my insurance company as requested, to share my billing information and intake information with Agapé secretarial staff, to share intake information with my insurance company or EAP provider, to contact my medical doctor as needed, and to provide counseling to my minor child as applicable.

____ Signature and Date

Physician Information/Authorization:

Family Physician:______________________________Clinic:________________

I hereby authorize Agapé Counseling Center to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally advising my therapist.

Physician name:____
Signature of Client: ____________________________Date:________________
Consent withdrawn on:____

Briefly described why you have come and what you hope to gain from counseling: