Erin Sanford, LPC-MH, NCC, QMHP
Jennifer Zerfas, LPC-MH, NCC, LAC, QMHP
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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: