GATEWAY COUNSELING CENTER, INC.

(417) 869-8400

CONFIDENTIAL Client Intake Information Form

Date:_____ Referred By:_____

Individual Information:

Name:_____
Last First M.I.

Address:_____
Street City State Zip

Date of Birth: _____Age:_____S.S.#:_____E-mail_____

Home Phone:(____)_____ Work Phone:(____)_____Cell Phone:(_____)_____

May we contact you at these numbers (check one)? ___Yes ___ No

May we leave a brief message at any of these numbers (check one)? ___All – ONLY: ___ Home ___Work ____Cell

Place of employment:_____

Additional Person Information (spouse, fiancé', parent, guardian, other):

Name:_____
Last First M.I.

Address:_____
Street City State Zip

Date of Birth: _____ Age:_____ S.S.#:_____

Home Phone:(____)_____ Work Phone:(____)_____Cell Phone:(_____)_____

May we contact you at these numbers if necessary (check one)? ___Yes ___ No

May we leave a brief message at any of these numbers (check one)? ___All or ___ Home ___Work ____Cell

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1983 E. Seminole St., Ste. B • Springfield, MO 65804
Phone: 417-869-8400 Fax: 417-869-8401

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Client Payment Information

Note: All records are confidential. No outsider is permitted to view your records without your written consent.

Please Check one:

□ Insurance Information:

Do you have Health Insurance (check one)? ___Yes ___ No

Do you want us to file your insurance(check one)? ___Yes ___ No

Insurance Provider:_____

Name of Policy Holder:_____

Relationship to client: _____

Policy Holder's Place of Employment:_____

Policy Holder's S.S.#:_____ Date of Birth:_____

Member policy #:_____ Group #:_____

□ Secondary insurance policy:

Insurance Provider:_____

Name of Policy Holder:_____

Relationship to client: _____

Policy Holder's Place of Employment:_____

Policy Holder's S.S.#:_____ Date of Birth:_____

Member policy #:_____ Group #:_____

□ Personal Payment:

Payment Method (check one)? ___Check ___Cash _____ Credit Card

Card Holders Name: _____ _____

Card#:_____ _____ Expires:_____

*If Client is self pay (insurance is not billed) - Terms agreed to by Counselor & Client (write below):

_____

_____

_____

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Guarantee of Payments

I, _____by my signature below agree to make payment in full for any services or other fees that are due Gateway Counseling Center, Inc. and am responsible for such payments independent from any efforts to obtain such payments from insurance or other financial providers. I hereby release Gateway Counseling Center, Inc. and their agents or other persons acting in their behalf from all harm and I hereby waive all rights to confidentiality in matters concerning collection of payments due. I accept full responsibility for any fees or other costs that may be incurred in the collection of payments due Gateway Counseling Center, Inc.

NOTICE OF CANCELLATION OR FAILURE TO SHOW FOR APPOINTMENT

I understand that it is my responsibility to give at least 24 hours notice to cancel a session. By my signature below I understand that I may be required to pay the session fee for each occurrence of a missed session or late cancellation.

_____

Client's Signature Date

_____

Client's Signature Date

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Description of Symptoms

This information is between you and your counselor only. Please fill it out as specifically as possible. If more room is needed please use the back of the sheet.

Describe briefly what main problems/issues prompted you to seek counseling at this time.

Describe the ways your problem interferes with your personal and work performance.

What have you already tried to do about this situation and what was the result?

When did the problem start?

How long have you been concerned about this issue (i.e. week, month, etc)?

Have you seen another counselor, psychologist, or psychiatrist about this issue? If so, when?:

Do you attend church? Denomination:

Please list any other health issues you are presently dealing with (heart surgery, thyroid, fibromyalgia, and/or other) :

Who is your physician? Physician's Telephone Number

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Please check all that apply to you even if it seems unrelated to your current counseling issue. Circle those of greatest concern to you currently.

RECENT CHANGES IN:
- Appetite
  - Increase
  - Decrease
- Weight
  ___lbs. lost/gained
- Physical energy
  - Increase
  - Decrease
- Health

CONFLICT WITH:
- Family Member
- Friend
- Colleague
- Boss
- Co-worker
- Other _____

THOUGHTS OF:
- Harming self
- Harming others

SLEEP DIFFICULTIES:
- Increase
- Decrease
- Difficulty falling asleep
- Early morning awaken

How many hours do you sleep each night?
_____

VICTIM OF:
- Accident
- Abuse
- Violent crime

ACCUSED OF:
- Abuse
- Violent crime

EXPERIENCE OF:
- Vivid dreams
- Nightmares
- Hearing voices
- Being out of body
- Visions

RELATIONSHIP STATUS:
- Single never married
- Single dating
- Single cohabitating
- Married
- Separated
- Divorced
- Re-married

How many times ____

FEELINGS OF:
- Anxiety
- Depression
- Dread
- Despair
- Low self worth
- Jealousy
- Tension
- Rage
- Persecution
- Boredom
- Loss of Interest

DECREASE CONTROL OF:
- Drinking
- Fighting
- Spending
- Sexual behaviors
- Stealing
- Gambling
- Eating
- Temper
- Relationships
- other _____

_____

FEAR OF:
- Loss of control
- Death
- Being alone
- Objects or animals
- Places/situations
- Cancer
- AIDS
- Being possessed
- Being insane
- other _____

_____

LIFE CHANGE (last 2 yrs.):
- Death in family
- Divorce/Separation
- Loss of Significant other
- Loss of a friend
- Fired from job
- Pregnancy
- Surgical/medical procedure
- Other _____

_____

Please list all medications, vitamins, and/or diet pills presently taking.

_____

_____

_____

_____

_____

_____

PRESENT USE OF:
- Alcohol
- Illegal drugs
- Cigarette smoking
- Prescription drugs
- Laxatives
- Diet pills
- Sleeping pills
- Other _____

_____

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