CONFIDENTIAL INTAKE FORM

Linda K. Halbert-Rhea, Ph.D.
Licensed Professional Counselor #0874
National Certified Counselor #46095
(CELL)662-889-2067; (FAX)1-866-542-8201
402 Wilkins Wise Road, Suite 27
Columbus, MS 39705

Name: _____ Email: _____ Date: _____

Home Address: _____

City: _____ State: ____ Zip: _____

SSN: _____ DOB: _____ Age: ____ Religion/Spirituality: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May I leave you a message to schedule/confirm appointments on voicemail, text, or email? Yes ___ No ___

Which means of communication do you prefer? Voicemail Text to cell phone Email

SEX:	ETHNIC GROUP:		RELATIONSHIP STATUS:	
1. Male	1. Black	4. Native Amer.	1. Single	4. Divorced
2. Female	2. White	5. Hispanic	2. Partnered	5. Widowed
	3. Asian	6. _____	3. Married	6. _____

Do you have children? Yes___ No ___ If yes, how many, what gender, what age(s)? _____

How do your religious/spiritual beliefs affect your daily life?

_____

_____

If you prefer NOT to have prayer, please intial: _____

Emergency Name: _____ Relationship _____

Emergency Phone:_____ Emergency Address: _____

FINANCIAL AGREEMENT

The undersigned does hereby acknowledge and accept financial responsibility for services rendered by Healing Hearts Counseling Services. The undersigned agrees to pay any and all co-pay and/or deductible fees due and owing at the time of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said provider to release information necessary to secure payment of services.

Signature of Client: _____ Date: _____

Please review the following lists and check any items that are of concern.

Physical

- ☐ Physical appearance
- ☐ Insomnia
- ☐ Fatigue
- ☐ Migraines
- ☐ Loss of appetite
- ☐ Decreased sex drive
- ☐ Thyroid problems
- ☐ Recent medical diagnosis (if checked, type of diagnosis _____)
- ☐ Any other physical ailments (if checked, describe_____)

Emotional

- ☐ Sad
- ☐ Anxious
- ☐ Fearful
- ☐ Lonely
- ☐ Angry
- ☐ Guilty
- ☐ Sense of loss/grief
- ☐ Overwhelmed
- ☐ Rejected
- ☐ Irritable
- ☐ Mood swings
- ☐ Any other emotion of concern (if checked, describe_____)

Thoughts, behaviors, experiences

- ☐ Inability to concentrate
- ☐ Lack of motivation
- ☐ Difficulty making decisions
- ☐ Relationship problems
- ☐ Family problems
- ☐ Abuse (physical, emotional, and/or sexual)
- ☐ Rape experience
- ☐ Confusion regarding sexual identity
- ☐ Use of alcohol
- ☐ Use of drugs
- ☐ Self-hurting (such as cutting)
- ☐ Thoughts of suicide
- ☐ Thoughts of homicide
- ☐ Any other thought, behaviors, and/or experiences of concern (if checked, describe_____)

Have you ever been diagnosed with the following? Please check all that apply.

- ☐ Clinical depression
- ☐ Post-partum (after giving birth) depression
- ☐ Anxiety disorder
- ☐ Eating disorder
- ☐ Any other mental health diagnosis (if checked, describe _____)

Briefly state what you would like to discuss with your therapist. How long has this concerned you?

What are your specific goals for therapy?