ANCHOR OF HOPE COUNSELING
110 Liberty Drive, Ste. 203, Clemson, SC 29631 (864) 654-7858

COUNSELING INTAKE FORM **Date: _____**

The information you provide below will help in providing services. All statements are confidential.

NAME: _____ S..S. #: _____

ADDRESS: _____(ZIP)_____

PERMANENT ADDRESS (if different): _____

TELEPHONE (H) _____ (W)_____(C)_____

DATE OF BIRTH: _____ AGE: _____SEX: _____ EMAIL:_____

Single __ Married __ Divorced __ Separated__ Widow__; Employed __ Student: Full-X ___ Part-X ___

OCCUPATION: _____

EMPLOYER: _____

REFERRED BY: _____

PHYSICIAN (name & address): _____

SPECIAL MEDICAL CONDITIONS: _____

MEDICATIONS: _____

ALCOHOL(+social): NO ___ YES ___; DRUG USE: NO ___ YES ___;

TOBACCO/VAP: NO ___ YES ___: PAST TRAUMA: NO ___ YES ___;

Please mark Yes or No for the following: ANY CURRENT SUICIDE / HOMOCIDE THOUGHTS ___ ;

ANY PAST ATTEMPTS: ____; ANY PSYC HOSPITALIZATIONS: ____

HAVE YOU EVER SOUGHT Professional Counseling or Psychological/Psychiatric Care: NO __ YES__
IF SO, WHEN:_____MAIN CONCERN? _____

IN EMERGENCY, CONTACT_____PHONE: (____)_____

INSURED'S NAME (if different): _____ Birth Date:_____

INSURED'S POLICY NUMBER: _____ Group Number:_____

INSURANCE COMPANY (name and address): _____

_____

INSURANCE COMPANY'S PHONE NUMBER: _____