Dr. Gregg Blanton
Intake Information Form

Name of Client_____ Today's Date_____

Address_____

City, State, Zip_____

Home phone_____ Work phone_____ Cell phone_____

Please circle numbers where you do not wish to be called, and indicate any restrictions (no messages left, etc.)

Birth Date_____ Age____ Birth Place_____ M_ F_ SS#_____

Occupation_____ Employer_____How long?_____

Education: Grade completed ____ College ____ Grad School___ Degree_____Institution_____

Local affiliation with house of worship_____

Minister's name_____

Marital status: Single___ Married___ Separated__ Divorced__ Widowed___ Partnered___

Date of: Marriage _____ Divorce _____ Death of Spouse _____

Children: Name Age Name Age

_____ _____

_____ _____

Spouse: Name_____Birth date_____Age_____

Social Security #_____Occupation_____Employer_____

Work phone_____Education_____Religious Preference_____

Family History:

Mother	Father
Name_____Age___ Deceased?___	Name_____Age___ Deceased?____
Married__ Separated__ Divorced__ Widowed___	Married__ Separated__ Divorced__ Widowed___

I was born the (first, second, third) _____of (two, three, four) _____children

Emergency Contact: Name_____Relationship_____

Address_____Phone_____Home__ Work__

Referral Source: Name_____ Title_____Agency_____

Address_____Phone_____

Do we have your permission to contact this person to thank them for the referral? Yes___ No___

Signed permission_____Date_____

(Please complete both sides of this form)

Problem or Stress Information:

What are you experiencing and/or what has happened to cause you to seek counseling?

_____

_____

Have you received previous counseling? Yes___ No___ Name of counselor(s) and date(s)_____

_____

Have you been hospitalized for psychiatric reasons? Yes___ No___ Explain_____

_____

General Health Information:

Names of primary care physician/other physician(s) or specialist(s)_____

_____Date of last physical exam_____

Medications presently taking_____

Known allergies/adverse reactions_____

Dates of surgical/invasive procedures_____

I am able to file with most insurance companies. **If for any reason, insurance denies the claim, full payment for that visit becomes the responsibility of the client**. If you would like me to file insurance, please (1)sign the following authorization statement and (2)provide me with a copy of your insurance card or complete the following:

I authorize insurance payment of medical benefits to the Growth Center for counseling services. I further authorize the release of medical or other information necessary to process an insurance claim.

Signature_____ Date_____

Please complete the following or we can make a copy of your insurance card.

Name and Address of Insurance Company_____

Policy Holder: Self____Spouse____Parent_____ Policy #_____Group #_____

Social Security # of Policy Holder _____

Is there other insurance? Yes____ No____ Company_____ Policy #_____

Who will be responsible for the bill?_____Relationship to the client_____

Any special circumstances you wish to make us aware of?_____

_____

I agree to counseling by Dr. Gregg Blanton. This person is licensed by the state to provide counseling with a faith perspective for persons with individual, couple, or family problems. I am aware that the counselor does not provide medical or legal assistance or psychological testing.

I agree to payment of fees after each session by check, cash, Visa or MasterCard to my counselor. **I agree to change or cancel appointments with a twenty-four (24) hour notice, or else pay $50 for the missed appointment.**

I understand that the information shared by either the counselor or the counselee is confidential and cannot be release to anyone without written consent except under the following conditions provided by the law:

- Imminent Danger--the law states that if we judge that you are a danger to yourself or others, we are required to take action to prevent harm from occurring to you or to others.
- Child abuse--we are required, by law, to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children to the Department of Social Services.

Signature_____ Date_____

Parent/Spouse/Partner Signature (if necessary)_____Date_____