ANEW HAVEN OF HOPE

Refreshed Hearts Newfound Joy

Counseling and Education Center

Anew Haven of Hope
1700 Burleigh Street
Yankton, SD 57078
605-260-9284

Client Information – Confidential

Please fill out fully to the best of your knowledge

Client: _____
Last Name First Name Middle Initial

Address: _____
Street/PO Box City State Zip Code

Gender: _____ **Age:** _____ **Date of Birth:** ____/____/_____

Telephone _____Cell/Home/Work

Occupation _____ **Employer** _____

Marital Status: ____Married ____Divorced ____Widowed ____Separated ____Living Together ____Single

Spouse/Partner: _____
Last Name First Name Middle Initial

Address: _____
(if different) Street/PO Box City State Zip Code

Gender: _____ **Age:** _____ **Date of Birth:** ____/____/_____

Telephone _____Cell/Home/Work

Occupation _____ **Employer** _____

Children:

_____
Name Age Gender

_____
Name Age Gender

_____
Name Age Gender

_____
Name Age Gender

Spouse/Partner's Children:

_____
Name Age Gender

_____
Name Age Gender

_____
Name Age Gender

_____
Name Age Gender

Custody arrangements _____

Others living in the home _____

Major Medical Issues or Surgeries_____

Medications _____

_____

_____

Current Physical Symptoms/Ailments_____

_____

Physician: _____**Location**:_____

Check all of the following that apply:

_____Stress	_____Grieving a Loss	_____Anxiety/Worry
_____Behavior Problem	_____Parent/Child Relationship	_____Depression
_____Phobia	_____Alcohol or Drug Use	_____Violence
_____Fear	_____Anger	_____Pain
_____Marital/Relationship	_____Abuse (physical,sexual,emotional)	_____Mood Swings
_____Sleep Changes	_____Health Problems	_____Appetite Issues
_____Self Harm	_____Difficulty Concentrating	_____Legal Issues

_____Others _____

Counseling Goals _____

Referred here by _____

Previous Counseling Experience_____

Counselor: _____

Insurance: If you have your card may we photocopy it for billing purposes?

_____Blue Cross/Blue Shield _____Avera Health Plan _____Medicaid

_____Other *(if other, please list)* _____

Name on Card: _____

Account Number: _____

Insurance Source (Employer, Self) _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Other Information: _____

Signature: _____**Date**: _____