Grief Recovery Center
2000 North Loop West Suite 210
Houston, TX 77018

Confidential Client Intake Information

The information you provide will be kept confidential and will be helpful in planning counseling services for you and/or your child. Please answer each item to your best ability.

Name ______________________________ Preferred name ______________

Address ____

City, state, zip code ____

Phone number ______________________ Permission to contact you here? ☐ Yes ☐ No

Email ___________________________Permission to contact you here? ☐ Yes ☐ No

Age _____ Birthdate __________________ Gender ______________________

Racial/ethnic identity ☐ African-American/Black ☐ Asian or Pacific Islander ☐ Caucasian/White ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Other ____________________

Referral Source ☐ Psychology Today ☐ Google ☐ EAP ☐ Family ☐ Friend ☐ Facebook ☐ Physician ☐ Former Client ☐ Insurance ☐ Therapist ☐ Other ____________________

Emergency contact name ______________________ Relationship ____________

Phone ____________________ Permission to contact in case of emergency? ☐ Yes ☐ No

Current occupation _________________________Employer ______________

Current relationship status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabitating ☐ Other ______________________________

Spouse/partner's name __________________ Age _____ Years in relationship ______

Names and ages of your children ____

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Family physician name ____________________________ Phone ____________

Psychiatrist name _________________________________Phone ____________

Please list any significant current or past medical problems ___________________________________

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Please list any prescription medications (dose, frequency) you currently take____________________

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Have you had previous counseling? ☐ Yes ☐ No

If yes, please give the name of the therapist(s), the year(s) you saw them (e.g., 2008 - 2009), and the nature of the difficulty at the time ____

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Have you ever been hospitalized for a psychiatric difficulty? ☐ Yes ☐ No

If yes, please give the year(s) and the nature of the difficulty at the time ________________________

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Please list any previous or current psychiatric diagnosis given by a professional __________________

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ADULTS: Please check primary reason(s) for seeking counseling:

☐ Anxiety ☐ Depression ☐ Grief/loss ☐ Nervousness ☐ Loneliness ☐ Loss of hope

☐ Conflicts at work ☐ Loss of job ☐ Compulsive behavior ☐ Eating/body image

☐ Abuse or assault ☐ Self-esteem ☐ Stress ☐ Alcohol/drug use ☐ Cutting/self-harm

☐ Suicidal thoughts ☐ Anger ☐ Chronic pain ☐ Appetite concerns ☐ Sleep concerns

☐ Legal issues ☐ Marital conflicts ☐ Family conflicts ☐ Relationship conflicts

☐ Gender identity ☐ Sexual/intimacy concerns ☐ Divorce adjustment ☐ Trauma

☐ Major life transition/change ☐ Eating disorder ☐ Other ____________________________

CHILDREN/ADOLESCENTS: Please check primary reason(s) for seeking counseling:

☐ Anxiety ☐ Depression ☐ Grief/loss ☐ Poor grades ☐ Truancy ☐ Running away

☐ Hyperactivity ☐ Fighting with peers ☐ Fighting with family ☐ Bed wetting ☐ Isolation

☐ Oppositional ☐ Parent – child conflict ☐ Teacher – child conflict ☐ Alcohol/drug use

☐ Sexual promiscuity ☐ Bullying ☐ Abuse ☐ Anger/aggression ☐ Crying ☐ Biting

☐ Kicking ☐ Spitting ☐ Yelling/cursing ☐ Self-harm/cutting ☐ Blended families conflict

☐ Adjusting to divorce/remarriage ☐ Eating disorder ☐ Cruelty to animals ☐ Poor focus

☐ Suicidal thoughts ☐ Suicide attempt(s) ☐ Other ______________________________

Please answer the next three questions regarding your presenting problems:

1. How severe do you consider your presenting problem/concern(s)?

☐ Not severe ☐ Somewhat severe ☐ Moderately severe ☐ Very severe

2. How motivated are you to resolve your presenting problem/concern(s)?

☐ Not motivated ☐ Somewhat motivated ☐ Moderately motivated ☐ Very motivated

3. How optimistic are you that your presenting problem/concern(s) can be resolved?

☐ Not optimistic ☐ Somewhat optimistic ☐ Moderately optimistic ☐ Very optimistic

What do you hope to achieve from counseling?

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Any other information you would like to share?

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Payment Information

Check one:

☐ PRIVATE PAYMENT - I do not intend to use mental health insurance to pay for my services at Grief Recovery Center. I understand that I am responsible for full payment for services at each visit.

☐ EAP (Employee Assistance Program)

☐ OUT-OF-NETWORK INSURANCE – I intend to use out-of-network insurance benefits to cover my services at Grief Recovery Center. I understand that I am responsible for full payment for services at each visit and will use a Superbill (provided by Grief Recovery Center) to seek reimbursement from my insurance company. I recognize that insurance companies vary in the percentages of reimbursement provided. I recognize that it is my responsibility to secure this preauthorization.

☐ IN-NETWORK INSURANCE – I intend to use my primary in-network insurance coverage benefits to cover my services at Grief Recovery Center. I understand that it is my responsibility for the deductible, co-payment and/or co-insurance amount for my visit at the time of service. I authorize Grief Recovery Center to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company, if any, be made to Grief Recovery Center, unless otherwise indicated on the claim. I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier. In making this assignment, I understand that I am financially responsible for any charges not paid under this insurance policy. I further understand that Grief Recovery Center will not file for secondary insurance on my behalf.

The following information applies to the insurance **policy holder**:

Policy Holder's Name (as it appears on card) ______________________________

DOB ______________________

Address ____

Insurance company name ______________________________________

Policy number ___________________________

Group and/or plan number ____________________

Policy holder's relationship to client ☐ Self ☐ Spouse ☐ Child ☐ Other _______________

____

Client Signature Date

____

Family Member/Guardian Signature (if applicable) Date