David M. Bradley, LMFT

Pastoral Counselor, Licensed Marriage & Family Therapist

Intake Information Form (Help Me Get to Know You)

Full Name ____ Date of Initial Visit_________________
Mailing Address____
City, State, Zip____
Home phone_____________ Work phone_____________ Cell Phone_____________ SS#_______________
Please circle numbers where you do not wish to be called, and indicate any restrictions (no messages left, etc.)
Birth Date_________ Birth Place___________________________________ Gender__________ Age______
Occupation________________________Employer________________________________How long?______
Education: Grade completed_____ College_____ Graduate/Technical School_____ Degree(s)_____________
Religious Preference: As a child__________________________Current______________________________
Local church affiliation__________________________________Minister's name______________________

Relationship Status: Single___ Married___ Separated__ Divorced__ Widowed___ Live-in___
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

Name____________________Age___ Deceased?___
Married__ Separated__ Divorced__ Widowed___

Father

Name___________________Age___ Deceased?____
Married__ Separated__ Divorced__ Widowed___

I was born the (first, second, third) ____________________of (two, three, four) __________________children

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Emergency Contact: Name_________________________________Relationship_________________________
Address____Phone_____________________Home__ Work__ Cell __

How Did You Hear About Me? Name_____________________Title______________________Agency____________
Address_____________________________________Phone_____________________Home__ Work __ Cell __

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Do we have your permission to contact this person/referral source 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?

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

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General Health Information:

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

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Date of last medical visit___________ Dates of major surgical procedures__________________________________

Medications presently taking____

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

I authorize insurance payment of medical benefits to David M. Bradley, LMFT 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:

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 you?__________________________

Any special circumstances you wish to make me aware of?____

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I agree to counseling by David M. Bradley, LMFT. He is licensed by the state to provide counseling for persons with individual, marital, 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 or cash. **I agree to change or cancel appointments with a twenty-four (24) hour notice, or else pay for the missed appointment, understanding that my insurance will not pay for missed appointments.**

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

1) Imminent Danger - the law states that if I judge that you are a danger to yourself or others, I am required to take action to prevent harm from occurring to you or to others.
2) Abuse – I am required, by law, to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children, the elderly, or disabled persons to the Department of Social Services.
3) Judges orders – on occasion, a Judge in a court of law might deem it necessary for records to be released.

Signature____ Date_________________

Parent/Spouse/Partner Signature (if necessary)__________________________________ Date_________________