Client Intake Form

Name____
Address____
____
Email ____
Work Phone ________________ Cell __________________ Home _______________
May I leave messages via phone? Yes ____ No _____
Annual Income (to qualify for sliding fee scale) ___________________________
Age______ Date of Birth ________ Relationship Status _________________________
Who referred you?___________________________ Today's date_________________

Person To Notify in an Emergency

Name_____________________________ Relationship to You________________________
Phone Numbers____

Presenting Concerns

Please check any concerns that are relevant to you at this time.

Career	**Overuse of**	**Self Concerns**
____ Change	____ Alcohol	____ Self Esteem
____ Choice	____ Marijuana	____ Perfectionism
____ Job Search	____ Drugs/medications	____ Anger/control/power
____ Information	____ Food	____ Insecurities/fears/worries
	____ Sex	____ Assertiveness/shyness
	____Other	____ Withdrawal
Relationship (s)	**Physical**	**Other**
____ Intimate Other	____ Sleeping	____ Intimacy
____ Parents	____ Eating	____ Loneliness
____ Children	____ Headaches	____ Sexual
____ Siblings	____ Abuse	____ Sexual/Gender Identity
____ Friends	____ Body Image	____ Suicidal Thoughts
____Co-workers	____ Other	____ Homicidal Thoughts
		____ Grieving/Loss

Please describe your primary reason for seeking counseling at this time?

Are you currently seeing another counselor or have you had previous counseling? If so, what type, when, with whom? Were these positive or negative experiences?

Are you presently on any medication? If so, what type, for what reason and who is prescribing this medicine?

Thank you for completing this form.
Lynne Milburn, LPC