Northwest Counseling
Individual and Family Therapy

CLIENT INTAKE FORM

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Primary Insurance Company: _____
Effective Date: _____
(If policyholder is different than client information above):
_____
First Name MI Last Name Social Security # _____
Address: _____
DOB: _____
Relationship to Client: _____
Employer: _____

Secondary Insurance Company: _____
Effective Date: _____
(If policyholder is different than client information above):
_____
First Name MI Last Name Social Security # _____
Address: _____
DOB: _____
Relationship to Client: _____
Employer: _____

It is your responsibility to inform Northwest Counseling of changes in address, phone #, and insurance coverage.

Birth Date: _____/_____/_ Age:_____ Gender: Male/Female
Name:_____
Address (Street and Number):_____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____
May We Leave a Message
- Yes
- No

Cell/Other Phone: (_____) _____-_____
May We Leave a Message
- Yes
- No

How do you want to receive appointment reminders?
- Email
- Text
- Phone
- I do not need reminders

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E-mail:
May We Email You?
- Yes
- No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:
Place of Employment:_____
Work Number: (_____) _____-_____
If needed, is it OK to call here?
- Yes
- No

Emergency Contact:
Name:_____
Relationship:_____
Phone Number: (_____) _____-_____

Date of first appointment:

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- Website: _____
- PsychologyToday: _____
- Friend/Family: _____
- Other: _____

Have you previously received any type of mental health services?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or
facility:_____

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Location:_____
__

Dates of
treatment:_____

Reason for
treatment:_____

Briefly, what brings you in today:

When did your problem first start? Within the last:

- 30 days
- 6--12 months
- 2 years
- During adolescence
- During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- Yes
- No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- Yes
- No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

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What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

Family of Origin

Please list your parents and siblings:

Name	Age	Relationship	If deceased, age and cause of death

Who did you live with while growing up? _____

Are your parents married?_____

If they divorced, how old were you when they divorced? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Yes/No	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Suicide Attempts	yes/no	
Obsessive Compulsive Disorder	yes/no	
Other diagnosed mental health condition	yes/no	Please list:

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Relationship:

Marital Status:

- Never Married
- Domestic Partner
- Married
- Separated
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased:
- If married, how long have you been married for and what is your partners name:_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?

- Yes -- How long? _____
- No

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If decease, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

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Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax:

_____

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____ What types of exercise do you participate in:

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Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe:

Current Use of Alcohol/Drugs

Circle average weekly alcohol intake:
- None
- 1-3 drinks
- 4-8 drinks
- More than 8

Circle recreational/mood enhancing nonprescription drug use:
- None
- Daily
- Weekly
- Monthly

Circle Type of Drug Used:
- Cannabis
- Cocaine
- Painkillers
- Speed
- Methamphetamine
- Other_____

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?
- Yes
- No
- Don't know

Lost time from school or work because of use?
- Yes
- No
- Don't know

Experienced a medical problem because of use?
- Yes
- No
- Don't know

Been fired from a job because of use and its effects?
- Yes
- No
- Don't know

Felt you ought to cut down on your drinking or drug use?
- Yes

- No
- Don't know

Had people annoy you by criticizing your drinking or drug use?

- Yes
- No
- Don't know

Felt bad or guilty about your drinking or drug use?

- Yes
- No
- Don't know

Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?

- Yes
- No
- Don't know

My average daily nicotine use is: _____
My average daily caffeine use is: _____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?