Client Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Name: ____
(Last) (First) (Middle initial)

Name of parent or guardian (if under 15 years old):

____
(Last) (First) (Middle initial)

Age: _____ Birthdate: ______________ Gender: ___ M ___ F

Marital Status: ___ Never Married ___ Married ___ Divorced ___ Separated

___ Widowed ___ Domestic Partnership

Please list any children and ages: ____

Home Address: ____
(Street Number)

____
(City) (State) (Zip Code)

Home Phone: _______________________________________ ____ yes ____ no
(okay to leave a message)

Cell/Other Phone: ____________________________________ ____ yes ____ no
(okay to leave a message)

Email: ____ ____ yes ____ no
please note that email is not always considered confidential (okay to email a message)

How did you find out about Kellyn Glynn Counseling, LLC: ___________________________

Referred by (if any): ____

Emergency Contact Information:

____
(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling or psychiatric services:
___ yes ___ no

If yes: ____
(Name) (Phone)

Health and Medical

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

____
____
____

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

____
____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

____
____
____

Please check from the following list any items that you have experienced recently:

___ Loss of interest in previously enjoyed activities
___ Overwhelming sadness
___ Crying often
___ Feeling hopeless
___ Overwhelming anxiety, panic, or worry
___ Frequent physical complaints (headaches, etc)
___ Significant change in weight
___ Trouble falling asleep or staying asleep at night
___ Racing or disorganized thought patterns
___ Thoughts of suicide
___ Irritability or anger
___ Mood shifts
___ Self Mutilation
___ Overindulgence in alcohol, recreational drugs, or sexual activity

Family History

Please list any medical (both physical and mental health) conditions that exist within your family, as well as the family member with the condition:

____
____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

____
____

Is there any history of suicide in your family? If so, please list:____

Do you have any siblings? If so, please list with ages:

____

Who do you turn to for support in your family?

____

Occupational and Social

Are you currently employed? ____ yes ____ no

if yes, what is your current occupation: ____

Do you enjoy your current profession? ____ yes ____ no

if no what would you change: ____

Please list any current legal troubles at this time, if any:

____

____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

____

____

What do you view to be your strengths as a person?

____

____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.

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