**Kathleen Leser, LCSW, LLC**

**CLIENT INTAKE FORM**

Date: _____

Name: _____
(Last) (First) (Middle Initial)

Preferred Name: _____ Gender: _____

Date of Birth: _____ Age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ Cell: _____

Work: _____

Which is the preferred contact phone? ___ Home ___ Cell ___ Work

May a message be left on this phone? ___ Yes ___ No

Will you be using insurance? ___ Yes ___ No

Name of Insurance Carrier: _____

Who referred you? _____

May I contact this person to thank them for the referral? ___ Yes ___ No

Emergency Contact:

Name: _____
(Last) (First)

Phone Number(s): _____

Relationship to you: _____

In the event of an emergency, I acknowledge that the above listed individual may be contacted.

_____
Client Signature

_____
Date

Marital Status: ___ Single ___ Married ___ Partnership
___ Separated ___ Divorced ___ Widowed

List any children and their ages. _____

_____

List who lives in your home, their ages and their relationship to you. _____

_____

_____

Are you employed? ___ Yes ___ No Employer: _____

Work Title / Position: _____

Length of time with current employer. _____

What are your reasons for seeking counseling at this time? _____

_____

_____

_____

Have you received behavioral health / mental health services previously? ___ Yes ___ No

If you have, please list provider's name and approximate dates of service. _____

_____

_____

Have you ever been given a mental health diagnosis? ___ Yes ___ No If you have, what was the diagnosis? _____

Are you currently taking psychiatric medication? ___ Yes ___ No If you are, please list name, dosage, frequency and purpose of medication. _____

_____

Are your currently taking any over the counter medications or herbal remedies for mood, stress or sleep? ___ Yes ___ No If you are, please list name, dosage, frequency and purpose of medication or herbal remedy. _____

_____

Have you ever been prescribed psychiatric medication? ___ Yes ___ No If you have, please list name and dates taken. _____

_____

How is your current physical health? ___ Poor ___Unsatisfactory ___ Satisfactory ___Good ___ Very good

List any physical health diagnoses and/or concerns. _____

_____

For any medications that you are taking for physical health reasons, please list name, dosage, frequency and purpose of medication. _____

_____

How many times weekly do you usually exercise? _____

What types of exercise do you participate in? _____

Do you drink alcohol? ___ Yes ___ No. If so, how much do you drink weekly? _____

_____

_____

Do you use drugs or take more prescription medication that is prescribed? ___ Yes ___ No

If so, please describe. _____

_____

Do you drink caffeinated beverages? ___ Yes ___ No. If so, how much do you drink daily?

_____

Do you smoke cigarettes? ___ Yes ___ No. If so, how much do you smoke daily? _____

_____

When you were growing up, who did you live with? List their names and relationship to you. _____

_____

_____

Listed below are a variety of concerns that may motivate people to seek counseling. Please circle those which apply to you.

| | | |
|---|---|---|
| Abuse | Alcohol | Anger, temper |
| Anxious, nervous | Appetite | Children |
| Compulsive behavior | Concentration | Depressed, low mood |
| Direction in life | Drugs | Eating |
| Family of origin | Financial | Grief / loss |
| Hallucinations | Homicidal thoughts | Irritable |
| Lack of interest, enjoyment | Lack of motivation | Loneliness |
| Low energy, tired | Marital / partnership | Memory |
| Mood swings | Parents | Physical health |
| Racing thoughts | Relationships | Religious, spiritual |
| Repetitive thoughts | Self-esteem | Self-injurious behaviors |
| Sexual identity | Sexual problems | Sleep problems |
| Stress | Suicidal thoughts | Transition |
| Unusual thoughts | Withdrawn, isolated | Work, career |

Other concerns: _____

_____

Thank you for taking the time to complete this form.