CLIENT INTAKE INFORMATION

This information is used by your therapist for administrative purposes, and to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be worked on in your counseling services. Please answer as thoroughly as you can. Thank you for giving us the opportunity to serve you.

Date ______________________

Client Information

First Name _________________________Middle Initial _________Last Name ___________________________

Nickname _________________________ Gender: □ Male □ Female

Date of Birth ______/____/________ Social Security Number____________________________
(required by most insurance companies)

Marital Status: □ Married □ Single □ Separated □ Divorced □ Other (explain)_________________

Employment: □ Employed □ Full-time Student □ Part-time Student □ Unemployed/Other

□ **HIPAA Agreement was provided (sign here):** ____

Telephone: ☐ Mobile ( ) _______________________ □ No messages □ Voice Messages □Text Messages

☐ Home ( ) _______________________ □ No messages □ Voice Messages

☐ Work ( ) _______________________ □ No messages □ Voice Messages □Text Messages

Preferred Phone:_____________________________

Email Address:____

Address ____
Street City State Zip

Employer ____

Employer Address____
Street City State Zip Phone

Occupation/Title/Position:____

405 S. Clairborne, Suite 1 Olathe, KS 66062 Phone 913-764-5463

Background Information

Spouse &/or Parents Name (circle which applies)________ ____
Date of Birth ________/______/________ Social Security Number_____________________________

Address ____________________________________Employer ____

Telephone: Mobile ( ) _________________ Work ( ) ____________ May I contact them at work? _____

Please list additional family members living with you:

Name | Relationship | Date of Birth | Employer/School

1. ____

2. ____

3. ____

4. ____

Who may we contact in the event of an emergency?
Name:____________________________________ Phone number:__________________________
Relationship?____

Please describe briefly the concern or situation, which led you to seek services at this time:

____

____

____

How long has this been a concern?________________________

Have you experienced this type of concern before? □ YES □ NO If so, when?___________________

Have you had any significant events, either positive or negative, occur recently or in a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, etc?
____

____

Physician ____
Name Address Phone #

Do you regularly have physical wellness check-ups? □ YES □ NO

If you have noticed any recent changes in the following areas, please circle those changes:

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking
B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

Are you currently seeing a counselor, therapist, psychologist, or psychiatrist □ YES □ NO
If yes, who?____

Have you ever had counseling before? □ YES □ NO
If so, when and why? ____
____

Was it helpful? □ YES □ NO If not, why not?____________________________________

Have you ever had medication prescribed for psychiatric or emotional difficulties? □ YES □ NO
If so, please list:
____
____

Have you ever been physically, sexually, or emotionally abused? □YES □ NO
If yes, briefly describe:
____
____

Have you ever been hospitalized for mental or nervous problems? □YES □ NO
If yes, when and where: ____

Are you experiencing any issues related to sexuality (i.e. sexual identity, compulsive pornography use, desire, performance, etc.)? □ YES □ NO
If yes, please explain:____
____
____

Have you ever attempted suicide? □ YES □ NO
If yes, how and when:____
____
Are you suicidal now? □ YES □ NO

How often do you drink alcohol? ____
Have you ever been arrested for driving under the influence (DUI)? □ YES □ NO

Do you smoke or use tobacco? □ YES □ NO
If yes, how much?____

Do you use recreational drugs? □ YES □ NO
If yes, what drugs do you use and how often?___________________________________

Do you have any concerns about alcohol/drug usage by members of your family? □ YES □ NO
If yes, please explain:____
____

Are you currently involved or expected to be involved in any court related matters? □ YES □ NO
If yes, please describe:____
____

Have any of your biological relatives had concerns similar to yours, or had any other psychiatric or emotional difficulties? □ YES □ NO
If yes, which relatives and what kind of concerns/difficulties:_______________________________________
____

Religious and Spiritual
Do you consider yourself spiritual? □ YES □ NO Religious? □ YES □ NO
Comment?____

Do you currently express this spirituality through religious practice? □ YES □ NO
Comment?____

Would you like spirituality included in your counseling? □ YES □ NO

Church affiliation____

How did you hear about Lifeline Counseling Center or your counselor (check all that apply)?
____Google _____Yahoo _____ Bing ____Facebook ____Psychology Today
_____Agency/Organization (which?_______________________________)
____Lifeline Counseling Website
____Pastor, Priest, Rabbi, Church, etc. (which?____)
____Insurance referral_____________________________ ____ Dr.____________________________
____Individual (who?_____________________________) ____Other (please specify______________)

If applicable, do I have permission to thank the person who referred you? □ YES □ NO

Contact Name and Number____

Demographic Information (optional…may skip this section and go to next page)

This information is confidential and used for statistical purposes. Providing demographic information is voluntary.

Ethnicity: ____Caucasian/White ____American Indian/Alaska Native ____Middle Eastern
____African American/Black ____Native Hawaiian/Pacific Islander ____Asian
____Hispanic/Latino ____Other ____________________________

Education of Adults in Household (put initials of each adult if more than one):
____Some High School ____Associate's Degree ____Doctorate
____High School Graduate ____Bachelor's Degree ____Trade/Specialty
____Some College ____Master's Degree ____Other __________________

Presenting concerns: (check all that apply – if attending couples or family counseling please put initials of each person next to the concerns that apply.)

___very unhappy
___insecurity
___irritable/critical
___no joy
___withdrawn/isolation
___tiredness

___impulsive
___obsessive/compulsive
___nervousness
___panic attacks
___racing thoughts
___fearful

___undependable
___intense headaches
___ temper outbursts
___employment problems
___repetitive/ritualistic behaviors
___seizures

___self-control
___ stealing
___bullying
___loneliness
___grief
___lying

___frustration
___moody
___depression
___memory loss
___short attention span
___concentration difficulty

___shyness
___worry
___health problems
___self-harming
___stressed out
___destructive

___financial stress
___legal problems
___problems w/ex-spouse
___sexual problems
___relationship issues
___affair

___flashbacks
___nightmares
___eating problems
___sleeping problems
___bed wetting
___school issues

___crying spells
___lack of energy
___lacks motivation
___difficulty making decisions
___emotional abuse
___sexual abuse
___physical abuse
___homicidal thoughts
___suicidal thoughts

___excessive daydreaming
___hair pulling
___mean to others
___distractible
___paranoia
___strange thoughts
___strange behavior

___divorce/separation
___significant alcohol use
___problems with friends
___parenting problems
___stomach/bowel problems
___chronic pain
___problems w/parents

___ work/career issues
___pornography use
___drug use
___social problems

Explain:____

____

____

____

____

What are your goals for treatment (what do you want to accomplish with counseling?)

1)____

____

2)____

____

3)____

____

Is there anything else that you feel is important for your therapist to know?

____

____