



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? <input type="checkbox"/> YES <input type="checkbox"/> 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 _____

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

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> very unhappy | <input type="checkbox"/> impulsive | <input type="checkbox"/> undependable | <input type="checkbox"/> self-control |
| <input type="checkbox"/> insecurity | <input type="checkbox"/> obsessive/compulsive | <input type="checkbox"/> intense headaches | <input type="checkbox"/> stealing |
| <input type="checkbox"/> irritable/critical | <input type="checkbox"/> nervousness | <input type="checkbox"/> temper outbursts | <input type="checkbox"/> bullying |
| <input type="checkbox"/> no joy | <input type="checkbox"/> panic attacks | <input type="checkbox"/> employment problems | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> withdrawn/isolation | <input type="checkbox"/> racing thoughts | <input type="checkbox"/> repetitive/ritualistic behaviors | <input type="checkbox"/> grief |
| <input type="checkbox"/> tiredness | <input type="checkbox"/> fearful | <input type="checkbox"/> seizures | <input type="checkbox"/> lying |
| | | | |
| <input type="checkbox"/> frustration | <input type="checkbox"/> shyness | <input type="checkbox"/> financial stress | <input type="checkbox"/> flashbacks |
| <input type="checkbox"/> moody | <input type="checkbox"/> worry | <input type="checkbox"/> legal problems | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> depression | <input type="checkbox"/> health problems | <input type="checkbox"/> problems w/ex-spouse | <input type="checkbox"/> eating problems |
| <input type="checkbox"/> memory loss | <input type="checkbox"/> self-harming | <input type="checkbox"/> sexual problems | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> stressed out | <input type="checkbox"/> relationship issues | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> concentration difficulty | <input type="checkbox"/> destructive | <input type="checkbox"/> affair | <input type="checkbox"/> school issues |
| | | | |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> excessive daydreaming | <input type="checkbox"/> divorce/separation | <input type="checkbox"/> work/career issues |
| <input type="checkbox"/> lack of energy | <input type="checkbox"/> hair pulling | <input type="checkbox"/> significant alcohol use | <input type="checkbox"/> pornography use |
| <input type="checkbox"/> lacks motivation | <input type="checkbox"/> mean to others | <input type="checkbox"/> problems with friends | <input type="checkbox"/> drug use |
| <input type="checkbox"/> difficulty making decisions | <input type="checkbox"/> distractible | <input type="checkbox"/> parenting problems | <input type="checkbox"/> social problems |
| <input type="checkbox"/> emotional abuse | <input type="checkbox"/> paranoia | <input type="checkbox"/> stomach/bowel problems | |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> strange thoughts | <input type="checkbox"/> chronic pain | |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> strange behavior | <input type="checkbox"/> problems w/parents | |
| <input type="checkbox"/> homicidal thoughts | | | |
| <input type="checkbox"/> suicidal thoughts | | | |

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?

