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	___impulsive	___undependable	___self-control
___insecurity	___obsessive/compulsive	___intense headaches	___ stealing
___irritable/critical	___nervousness	___ temper outbursts	___bullying
___no joy	___panic attacks	___employment problems	___loneliness
___withdrawn/isolation	___racing thoughts	___repetitive/ritualistic behaviors	___grief
___tiredness	___fearful	___seizures	___lying
___frustration	___shyness	___financial stress	___flashbacks
___moody	___worry	___legal problems	___nightmares
___depression	___health problems	___problems w/ex-spouse	___eating problems
___memory loss	___self-harming	___sexual problems	___sleeping problems
___short attention span	___stressed out	___relationship issues	___bed wetting
___concentration difficulty	___destructive	___affair	___school issues
___crying spells	___excessive daydreaming	___divorce/separation	___ work/career issues
___lack of energy	___hair pulling	___significant alcohol use	___pornography use
___lacks motivation	___mean to others	___problems with friends	___drug use
___difficulty making decisions	___distractible	___parenting problems	___social problems
___emotional abuse	___paranoia	___stomach/bowel problems	
___sexual abuse	___strange thoughts	___chronic pain	
___physical abuse	___strange behavior	___problems w/parents	
___homicidal thoughts			
___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?

____

____