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Licensed Mental Health Counselor and Clinical Hypnotherapist

CLIENT INTAKE FORM

Please provide the following information in as much detail as possible. Please print. This information is confidential and protected as your Personal Health Information (PHI). It will help us get to know you better and start where you are at.

Date: _____

Client Personal Information

Client Full Name: _____

Complete Address: _____

Home Phone: _____ Ok to call? ◯ Y ◯ N Ok to leave message? ◯ Y ◯ N

Work Phone: _____ Ok to call? ◯ Y ◯ N Ok to leave message? ◯ Y ◯ N

Cell Phone: _____ Ok to call? ◯ Y ◯ N Ok to leave message? ◯ Y ◯ N

Ok to Text message? ◯ Y ◯ N

Email: _____ Ok to email? ◯ Y ◯ N

(Note: Phone and text messages, unless password protected, are not considered to be a confidential form of communication and therefore no confidential information will be sent via these forms of communication, however, appointment reminders are sent via text message, if requested.)

Date of Birth: _____ Age: _____ Gender: _____

Place of Birth: _____

Marital Status: ◯ Unmarried ◯ Married ◯ Domestic Partnership ◯ Separated ◯ Divorced ◯ Widowed

Spouse/Partner's Name: (if applicable)_____

Date of Birth: _____ Age: _____

Please describe any relationship concerns you may be experiencing:

Children: ◯ Yes ◯ No (If Yes, please note names and ages and any relevant pregnancy, labor and delivery information)

Level of Education: _____

Occupation:_____

How satisfied are you at work: ◯ Unsatisfied ◯ Neither ◯ Satisfied ◯ Very Satisfied

In case of Emergency, who may we contact:

Name: _____ Phone: _____

Health & Medical Information

Do you have a regular physician: ◯ Y ◯ N

Name_____ Location_____

Do you have any conditions or health concerns that you would like me to be aware of:

Are you currently taking any medications: ◯ Y ◯ N (If Yes, please list below name and dosage)

Please describe your current use, if any, of alcohol and/or non-prescription drugs: (what, how often, how much)

Any significant changes in sleep, appetite or eating patterns that have been of concern:

Have you ever tried to hurt or harm yourself: ◯ Y ◯ N (If Yes, please discuss below)

Additional Information

Hobbies and interests:

Spiritual or religious beliefs and how they influence your life:

Who is your greatest support:

Goals for Services

Please discuss what you would like to change or improve in your life:

How has this impacted your life:

How long has this been a concern:

What significant changes have you noticed lately: (please describe both positive and negative)

_____

_____

Have you experienced any significant life changes or stressful events recently:

What are some of your strengths:

What brought you work with me at this time:

_____

How will you know when you have reached your goal:

Who might be the first to recognize change or improvement:

Anything else you would like me to know:

Have you had prior counseling or coaching services? ◯ Y ◯ N (If Yes, please note below)

When:_____Where:_____

Whom may I thank for referring you: (Referral or Self-referred)

Name: _____ Phone:_____

Self referral via: _____