Shannon Davis-Wills LPC
CLIENT INTAKE FORM

Welcome! Thank you for taking the time to fill out this form. The information you provide is confidential and will be helpful for you and your counselor when you meet for the first time. If you have any questions, please ask.

Today's Date: _____

Client Name:_____

Age _____ Date of Birth: _____

Birthplace: _____

SSN: _____

Client Address:

_____

_____

Phone:_____ Work_____

Email address: _____ Male _____ Female_____

Can voice messages be left? _____

Do you want text appointment confirmations, if so what number do you wish to be contacted on?

_____

Ethnicity: __ Black __ White __ Hispanic __ Asian/Pacific Islander __ Native American __ Other

Marital Status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/Partner's name: _____ Age: _____

Years in relationship: _____

Children (gender and age): _____

Referred by: _____ Highest Education Level: _____

Occupation: _____ Name of Employer: _____

Emergency Contact: _____

Phone: _____ Relationship to client: _____

Physician(s):_____ Phone: _____

Please describe any significant current or past medical problems:

_____

_____

Medications (List any medications you are currently taking):

_____

_____

Have you previously received psychological care or counseling? · Yes · No

If yes, please provide the name of the clinician(s), the time period you received service, and nature of the challenges you
experienced at that time.

_____

_____

Have you ever been hospitalized for a psychological difficulty? · Yes · No

If yes, please provide the dates and nature of the difficulty at that time:

_____

_____

In your own words, what is the inciting event or concern that has resulted in this appointment? Feel free to describe in as much or as little detail as possible.

_____

_____

What do you hope to accomplish in therapy?

_____

_____

Check all that apply to you:
___ Depression
___ Low Energy
___ Low Self-esteem
___ Poor Concentration ___ Hopelessness
___ Worthlessness
___ Guilt
___ Sleep disturbance (more/less)
___ Appetite disturbance (more/less)
___ Thoughts of hurting yourself
___ Thoughts of hurting someone
___ Isolation/social withdrawal
___ Sadness/loss
___ Anxiety/panic

___ Heart pounding/racing
___ Excessive behaviors (spending, gambling, etc.) ___ Not thinking clearly
___ Chest pain
___ Trembling/shaking
___ Sweating
___ Chills/hot flashes (non-menopausal)
___ Tingling/numbness
___ Fear of dying
___ Fear of going crazy
___ Nausea
___ Phobias
___ Obsessions/compulsive behaviors ___ Thoughts racing
___ Can't hold onto an idea
___ Feeling that you are not real
___ Easily agitated
___ Feeling that things around you are not real ___ Lose track of time
___ Unpleasant thoughts won't go away
___ Anger/frustration
___ Defies rules
___ Blames others
___ Argues
___ Excessive use of drugs and/or alcohols
___ Excessive use of prescription medications ___ Blackouts
___ Physical abuse issues
___ Sexual abuse issues
___ Spousal/Partner abuse issues
___ Other problems/symptoms
___ Delusions/hallucinations
_____
_____

I hereby consent to treatment from this provider. Although the chances of obtaining my goals for therapy will be best met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however for any balance due prior to a decision to discontinue.

Client Signature: _____

Date: _____