Date of Intake: ________________
Type of Intake: NEW RE-ADMISSION
Client Number: _________________
OFFICE USE ONLY

Laura Lewis LMFT

Individual & Family Counseling

CLIENT INFORMATION

Client's Name: ____ Date: ____/____/______

Gender Male Female Date of Birth: ______________________ Age: _____________

Address: ______________________________ City: _________________ State: ________ Zip _________

Contact Phone Number: _________________________ Email: ______________________________________

Employer: _____________________________________ Occupation: ____________________________

Marital Status:
Single Married Separated Divorced In a relationship Engaged Other __________________

Name of Spouse/Partner: ____

Contact Phone Number: _________________________ Email: _____________________________________

Emergency Contact: ______________________________ Relationship to You: _______________________

Contact Phone Number: ___________________________ Email: ___________________________________

FINANCIAL RESPONSIBILTY:

Please indicate who will be responsible for payment:

Self Spouse Parent Other _______________________________

Name of responsible party: ____

Address of responsible party: ____

Contact Phone Number: ______________________________ Email: _________________________________

You have the right to file all counseling services with your insurance company. Reimbursement for services is never guaranteed and payment for counseling services is expected at the time of service. If you would like a Superbill for your insurance company, please check this box ☐. Superbills are mailed/emailed once per month.

Family Dynamics

Relationship	Name	Age	Living (check if YES)	Living with You (check if YES)
Mother				
Father				
Spouse/Partner				
Child				
Child				
Child				
Child				

Significant Others (e.g. siblings, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living (check if YES)	Living with You (check if YES)

Please acknowledge any significant family events (e.g. death, divorce, illness, affair, physical/emotional/sexual abuse):
____

Briefly describe your past and current relationship with your:

Mother:	**Father:**
Step Mother:	**Step Father:**

Parental Information

☐ Parents legally married for _____ years
☐ Parents have ever been separated
☐ Parents ever divorced
☐ Mother remarried: Number of times __________
☐ Father remarried: Number of times __________

How would you describe your parents relationship with each other?
____

COUNSELING HISTORY

Have you been previously involved in individual counseling? YES □ NO □

If YES, whom have you seen?

Name: ______________________________ When: ____________________

Name: ______________________________ When: ____________________

Name: ______________________________ When: ____________________

Have you ever been hospitalized for mental health reasons? YES □ NO □

If YES, please explain:

____

____

____

Have you ever participated in Residential Treatment and/or Partial Hospitalization for any mental health issue? YES □ NO □

If YES, please explain:

____

____

____

Is there a history of mental illness in your family? YES □ NO □

If YES, please explain:

____

____

____

Have you ever attempted suicide? YES □ NO □

If YES, please explain:

____

____

____

Have you ever engaged in self-harm behaviors (e.g. cutting, scratching, hair pulling, burning)? YES □ NO □

If YES, please explain:

____

____

____

CURRENT SYMPTOMS CHECKLIST

Please rate the intensity of symptoms **currently** present.

None= This symptom not present at this time
Mild= Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate= Significant impact on quality of life and/or day-to-day functioning
Severe= Profound impact on quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe
Agitation				
Anger				
Anorexia				
Anxiety/Worry				
Binge Drinking				
Bingeing/Purging				
Body Image				
Bulimia				
Conflict with Child				
Conflict with Parent				
Crying				
Depression				
Fear				
Grief/Loss				
Guilt				
Hyperactivity				
Impulsivity				
Inability to Focus				
Irritability				
Laxative/Diuretic Use				
Mood Swings				
Nightmares				
Panic Attacks				
Passivity				
Procrastinating				
Relationship Issues				
Self- Injury				
Sexual Functioning Problems				
Sexual Identity Issues				
Social Isolation				
Spiritual Issues				
Substance Use/Abuse				
Suicidal Ideation				
Weight Gain				
Weight Loss				
Other:				

SUBSTANCE USE HISTORY

Substance	Frequency of Use	Age at first use	Age at last use	Used in last 48 hours (check if YES)	Used in last 30 days (check if yes)
Alcohol					
Barbiturates					
Valium					
Cocaine/Crack					
Heroin/Opiates					
Marijuana					
PCP/LSD					
Methamphetamine					
Inhalants					
Nicotine					
Caffeine					
Prescription Drugs					
Other					
Other					

Have you ever sought help for substance abuse? YES □ NO □

If YES, please explain:

____

____

____

MEDICAL HISTORY

Who is your primary care provider? Include phone number. ______________________________

List all prescribed medications:

Medication	Dosage	Prescribed by...

Indicate whether you have or have had any of the following:

Allergies
Abortion
Asthma
Arthritis
Cancer
Chest Pain
Chronic Pain
Dental Problems
Diabetes
Dizziness
Epilepsy
Ear Infections

Eating Disorder
Fainting
Fatigue
Headaches
High Blood Pressure
Kidney Problems
Miscarriage(s)
Neurological Disorders
Nausea
Sexually Transmitted Disease
Sleep Disturbance
Sinus Problems

Stroke
Sexual Problems
Thyroid Problems
Vision Problems
Vomiting
Other: ______________________
Other: ______________________
Other: ______________________

List any current health concerns: ____

List any recent health or physical changes: ______________________________________

List any past surgeries:

____

____

List any past hospitalizations (for non mental health issues):

____

____

List all medications (with dosages):

____

____

Have you ever been diagnosed with an eating disorder:_____________________________

TREATMENT GOALS

Please identify areas you would like to work on in counseling:

____

____

____

____

____

____

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, I am required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions, please let me know.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORM, INCLUDING THE CLIENT NOTIFICATION OF PRIVACY RIGHTS SECTION.

_______________________________ _________________

Client/Guardian Signature Date