Kinsie M. Tate LPC, LLC *Client Intake Form*

Name:_____ Date:_____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:_____

Have you previously received any type of mental health services? Yes No
If yes, which of the following:

- ☐ Psychotherapy (name of provider _____)
- ☐ Medication
- ☐ Outpatient Hospitalizations (name of facility _____)
- ☐ Inpatient Hospitalization (name of facility_____)

Reason for treatment:_____

Briefly, what brings you in today and how long ago did it begin?

What areas of your life have been affected because of this?

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No
If yes, when did you begin experiencing this?_____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born?_____

Where did you grow up?_____

- ☐ City
- ☐ Suburbs
- ☐ Country

Please list your parents and siblings. Please use additional space on back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death?

Who did you live with while growing up?_____

Mother's occupation: _____

Father's occupation:_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please circle**		**List Family Member**
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Domestic Violence	Yes	No	
Sexual Abuse	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Obsessive Compulsive Disorder	Yes	No	
Schizophrenia	Yes	No	
Suicide Attempts	Yes	No	
Other mental health condition?	Yes	No	

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced—For how long?
- ☐ Widowed: Please provide your partners name and how long deceased:

If married, how long have you been married and what is your spouse's name? _____

On a scale of 1-10 (10 best), how would you rate your relationship? _____

Are you currently in a romantic relationship? (if single or married in relationship with someone other than spouse) Yes, how long _____ No

On a scale of 1-10 (10 best), how would you rate this relationship?_____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If decease, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider:_____

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please describe any sleep problems you are currently experiencing:

How many times and what type of exercise do you participate in?

Are you currently experiencing any chronic pain? Yes No
If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What is your profession (full-time homemaker and retired included)?_____
What do you/did you enjoy about your work?

What do you find particularly stressful?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?