Kaitlyn Nicholson, MMFT

Client Intake Form

Basic Information

Name: _____ Date: _____

Address: _____

_____

Phone: (C)_____(H)_____(W)_____

Email: _____Contact by **Phone** or **Email** (circle one)

Age: _____ DOB: _____

Employer: _____ Occupation: _____

Do you enjoy work? Y or N

If no, please describe what you would like to change: _____

_____

Do you consider yourself to be spiritual? Y or N

If yes, please describe your faith or belief: _____

_____

Personal Information

Relationship Status: (circle one) **Single** **In Committed Relationship (years together____)**

Married (years married ___) **Separated** **Divorced** **Widowed**

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

Name of Spouse: _____

Children and Ages: _____

Siblings: _____

Referred by: _____

Previous Counseling? (circle one) **yes no**

If yes, please list treatment dates: _____

If yes, what was your experience of therapy like? _____

Medical/Mental Health Information

What mental health services have you previously received? (Psychotherapy, Psychiatric, etc.)

_____

What, if any, medical health problems do you have? _____

_____

_____

Physician: _____ Current Medications: _____

Are you currently taking any medication for a mental or emotional condition? _____

If so, please list conditions, medications and dosage: _____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

Is there any history of mental or emotional conditions in your family? _____

If yes, explain: _____

Is there any history of addiction in your family? _____

Have you had any suicidal thoughts in the past or present? (circle one) **yes no**

Have you had any suicidal attempts in the past or present? (circle one) **yes no**

If yes, please explain: _____

Do you use any controlled substance or alcohol on a regular basis? (circle one) **yes no**

If yes, how often to you use alcohol or recreational drugs? (circle one)

Daily Weekly Monthly Infrequently

Are you currently in any outpatient treatment or utilizing any support groups such as AA?

(circle one) **yes no**

On a scale of 1-10, rate your current physical health: _____

On a scale of 1-10, rate your current sleep habits: _____

On a scale of 1-10, rate your current eating habits: _____

Do you exercise regularly? **yes no**

If yes, how many days per week do you exercise? _____

What types of exercise do you participate in? _____

Please circle any of the following that you experience problems with and rate on a scale of 1-10 (10 being most severe):

Anger	Depression	Pornography
Loss/Grief	Lying	Job stress
Self-esteem	Worry	Relationships
Guilt/shame	Marriage problems	Suicidal thoughts
Mood swings	Obsessive thoughts	Self-injury
Communication	Sleeping problems	Crying Spells
Spiritual/Religious	Legal Problems	Disordered eating
Medical/Pain	Anxiety/Panic	Body Image

For each circled item above, list how long you have been struggling with this problem:

_____

_____

_____

_____

Have you experienced a loss or trauma in the recent past? (circle one) **yes no**

If yes, what was the relation to the person involved? _____

If yes, list the nature and date/s of the loss or trauma experience: _____

_____

List any other significant life changes or stressful events you have experienced recently:

_____

_____

_____

Reason for seeking counseling:

_____

_____

_____

_____

Desired Outcome/Goals for Therapy?

_____

_____

What do you consider some of your strengths/weaknesses? _____

_____

_____

<u>Emergency Contact Information</u>

Name: _____ Phone: _____

Relation to client: _____

I certify that the information contained herein is complete and accurate, to the best of my knowledge. I voluntarily consent to the counseling that I receive from Kaitlyn Nicholson, MMFT.

Client Signature: **Date:**

_____ _____