

La Fleur Counseling, PLLC
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425.681.1528 FAX 425.332.7202

Client Intake Form

Name _____ Age _____ Date of Birth _____

Address _____

Cell Phone _____ Is it okay to leave a message? Y / N

Email _____ Is it okay to contact you via email? Y / N

Preferred way to contact you? _____

How did you hear about my services? _____

Physician's Name _____

Name of Employer or School _____ Grade _____

Gender Identification _____ Sexual Orientation _____ Sexually Active Y / N

Relationship Status ___ Single ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed

If under 18, relationship with parents: ___ OK ___ Good ___ Challenging ___ Would like to improve it

If under 18, Parent's Relationship status ___ Single ___ Dating ___ Partnered ___ Divorced ___ Married

Who are the people you live with? Please provide name, age, and relationship.

Name	Relationship	Age	How would you describe the relationship?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Health Information

Have you ever had counseling before? Y / N If yes, please describe the reason, the therapists name, approximate dates and whether the counseling was helpful.

Briefly describe what brings you to counseling today?

What goals would you like to achieve from counseling?

Medication Information

Name of Medication

Dosage

Date Started

Prescribing Physician

Please check any of the following issues that are a concern for you.

<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	School or Work Issues	<input type="checkbox"/>	Suicidal Thoughts/Attempts
<input type="checkbox"/>	Depressed Mood	<input type="checkbox"/>	Relationship Issues	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	Sexual Issues	<input type="checkbox"/>	Grief / Loss
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	Legal Problems
<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Self Esteem	<input type="checkbox"/>	Physical Health Problems
<input type="checkbox"/>	Anger	<input type="checkbox"/>	Repetitive Thoughts	<input type="checkbox"/>	Urges to harm Others
<input type="checkbox"/>	Disordered Eating	<input type="checkbox"/>	Repetitive Behaviors	<input type="checkbox"/>	Stress
<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	Cutting / Self Harming	<input type="checkbox"/>	Chronic Pain
<input type="checkbox"/>	Emotional Abuse	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	Physical Abuse
<input type="checkbox"/>	Financial Concerns	<input type="checkbox"/>	Blended Family Concerns	<input type="checkbox"/>	PTSD

Have you ever been hospitalized or gone to the emergency room? Y / N If yes, please describe:

Date(s) of Hospitalization

What Facility

Reason for Hospitalization

Please List any diagnosis you have received in the past

Diagnosis

Date of Diagnosis

Who made this Diagnosis?

Who in your immediate family has experienced the following?

M (mom)

D (dad)

S (sibling)

GP (Grandparent)

<input type="checkbox"/>	Drug / Alcohol Abuse	<input type="checkbox"/>	Prescription Drug Abuse	<input type="checkbox"/>	Disordered Eating
<input type="checkbox"/>	Depression / Anxiety	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	Mental Health Issues
<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	Self-Harming Behavior	<input type="checkbox"/>	Anger Problems

Have you ever experienced any traumas or losses in your life? Y / N If yes, please describe briefly:

Who do you turn to for support? _____

Substance Use History: Have you ever used the following?

	How Often?	How Much?	Date of Last Use?
Alcohol			
Marijuana / Dabs			
Cocaine / Crack / Meth			
Prescription Pain Meds			
Xanax / Klonopin			
Heroin			
Hallucinogens			
Ecstasy / Molly			
Energy Drinks			
Spice			
DXM			
Ritalin / Adderall			
Nicotine			
Other:			

Have you ever experienced any consequences (Family, Physical, Legal, Work, School) due to your use? Y / N

Have you ever had drug / alcohol counseling? Y / N If yes, when and where?

Has anyone ever thought you had a problem with substances? Y / N Who? _____

*****Emergency Contact Numbers*****

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Client Signature: _____ Date: _____

Client / Parent Signature: _____ Date: _____