Mary Walseth, M.A., LPC

Client Intake Form

All information you supply is protected under the State of Texas and ACA confidentiality guidelines

Section I: DEMOGRAPHIC INFORMATION

Date: _____

Name: _____

Address: _____ City/State: _____ Zip: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Note: HIPPA requires your written permission to contact you via snail mail, e-mail and phone. May we send communication to your physical and/or e-mail address? Circle: Yes No

E-mail address (optional): _____

If we call, on which number(s) may we leave a message? Circle: Any Home Work Cell
May we text your cell phone regarding appointments? Circle: Yes No

Your Birth Date: _____ Age: _____

Your Education (last grade or college you completed): _____

Your Occupation: _____

How did you hear about us? (Check one)
_____ Your Insurance Provider
_____ Google/Internet Search
_____ Medical or Clinical Professional: If so, name: _____
_____ Friend or Family Member

Section II: FAMILY BACKGROUND

Immediate Family: Circle: Spouse/Partner Name: _____
Years together/married: _____

Are your parents living? Mother Circle: Yes No (Year deceased _____)
Father: Circle: Yes No (Year deceased _____)

Did your parents divorce? Circle: Yes No

Section II: FAMILY BACKGROUND (continued)

If your parents divorced, how old were you at the time? _____

Do you have stepparents? Stepmother: Yes No
Stepfather: Yes No

Do you have children? Circle: Yes No

Please list name(s) and age(s) of your children. (Designate which are your children and which are your stepchildren, if any.)

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____
5. _____ Age: _____

List your siblings, including yourself, starting with the oldest child (include any deceased siblings)

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____
5. _____ Age: _____

Section III: BASIC HEALTH & COUNSELING HISTORY

How do you rate your overall health: Check one:
_____ Good _____ Fair _____ Poor Date or approximate date of last physical: _____

Name of Primary Physician: _____ Phone #: _____
Address: _____
May we contact your physician: ☐ **YES** ☐ **NO** ☐ **I DO NOT HAVE A PHYSICIAN**

Name of Psychiatrist: _____ Phone #: _____
Address: _____
May we contact your psychiatrist: ☐ **YES** ☐ **NO** ☐ **I DO NOT HAVE A PSYCHIATRIST**

Section III: BASIC HEALTH & COUNSELING HISTORY (continued)

Are you taking any prescription medications, vitamins or herbal remedies on a regular basis? If so, please list what they are and what they are for. (Example: Prozac – Depression)

_____
_____
_____

Have you been hospitalized in the last 3 years? If so, for what? _____
_____
_____

Do you drink alcohol? Yes No If yes, how much/how often? _____
Do you use illegal drugs? Yes No If yes, how much/how often? _____

Do you have any physical, emotional or mental condition (now or in the past) that we need to be aware of? Circle: Yes No If yes, please explain: _____
_____
_____

Have you had counseling in the past? Yes No Was it a good experience? Yes No

Do you have, or have you had, any bodily aches and pains? Yes No
If yes, please explain: _____
_____
_____

For each item you circle below, give details on the frequency AND severity to each "Yes" response:

			Frequency and Severity Level
Chronic Pain	Yes	No	_____
Migraines/Headaches	Yes	No	_____
Stomach Problems	Yes	No	_____
Thyroid Issues	Yes	No	_____
Cancer	Yes	No	_____
Heart Disease	Yes	No	_____
Diabetes (and type)	Yes	No	_____

Section III: BASIC HEALTH & COUNSELING HISTORY (continued)

Carpel Tunnel	Yes	No	_____
Numbness, Tingling	Yes	No	_____
Panic/Anxiety Attacks	Yes	No	_____
Depression	Yes	No	_____
Feeling spacey or "out of body"	Yes	No	_____
Phobias/Fears	Yes	No	_____
Extreme Fatigue or Little Energy	Yes	No	_____
General Anxiety	Yes	No	_____
Sleep Issues	Yes	No	**If yes, check any symptoms below that apply:**

___ Difficulty falling asleep
___ Difficulty staying asleep
___ Sleeping, waking, and unable to fall back to sleep
___ Sleeping too much

How many hours a night do you usually sleep? _____
Is that amount usual for you? Yes No

Please rate your overall energy by answering the statement in italics by checking the best response.
Statement: *"I am exhausted/tired and have little energy…"*
_____ Always _____ Most of the Time _____ Half of the Time _____ Sometimes _____Rarely
_____ I have plenty of energy

Answer the following statements by circling one response for each:

"I have lost interest in many things I once enjoyed doing."	TRUE	FALSE	Unsure
"I have racing thoughts and find it difficult to concentrate."	TRUE	FALSE	Unsure
"I feel afraid much of the time."	TRUE	FALSE	Unsure

Are you currently having any thoughts of suicide? Yes No

Do you have any syndrome(s), disease(s), condition(s) or illness(es) that we need to be aware of?
Yes No
If yes, please briefly explain:

How many times per week do you exercise? _____ Type of exercise: _____

Section III: BASIC HEALTH & COUNSELING HISTORY (continued)

Please list any difficulties you experience with your appetite or eating patterns?

_____
_____
_____
_____
_____

Section IV: YOUR REASONS FOR SEEKING COUNSELING

Please answer the following to the best of your ability. If you need more space, please use the back of this page or attach another sheet of paper:

(1) Why did you make the effort to call a professional counselor?

_____
_____
_____
_____
_____
_____
_____

(2) What would you like to see happen for yourself as the result of counseling?

_____
_____
_____
_____
_____
_____
_____

(3) What issue(s) concern you the most at this time?

_____
_____
_____
_____
_____
_____
_____

Is there anything else you think is important for us to know right now that is not covered in the above 3 statements? If so, please describe:

Please list any major changes or stressors in your life occurring in the last 12 months (for example, Separation, Divorce, Death of a Family Member, Loss of a Job, Major Illness, Moving, etc.):

Section V: IMPORTANT ADDITIONAL INFORMATION

A counseling session is normally 50 minutes, although the first session can run 90 minutes if paperwork is not completed prior to the appointment. Self-payments or co-payments are expected at the beginning of each session. Please give 24-hour notice if an appointment needs to be rescheduled. (See the Informed Consent & Service Agreement for further information with regard to client fees, rights and responsibilities.)

We will always maintain confidentiality with regard to content of your sessions and personal and financial information (see Informed Consent & Service Agreement). ***You must also sign a Limitations of Liability form which will be a part of your New Client Intake packet. We are required to report any suicidal threats, homicidal threats, or child/elder abuse under the rules of the State Licensing Board and under Texas State law.***

I understand that I have a right to refuse treatment at any time. I also understand that payment under the refusal of treatment right does not apply if 24-hour advance notice of cancellation is not given, as stated in the Informed Consent & Service Agreement.

Signed and Agreed to By:

_____ Date: _____

Mary Walseth, M.A., LPC
License # 63131

_____ Date: _____

Client Signature (Guardian if client is a minor)

_____

Please Print Your Name