Lindsay-Blair Simmons, LMFT
Client Intake Form

Name: ______________________________________ Age:____ DOB:________

Address: ____

City: ________________________ State: _____ Zip: ____________

Phone #: ___________________ Email: _______________________________

Emergency Contact (Name/Phone): ___________________________________

Who referred you? ____

Have you ever been in counseling before? ___Yes ___No

If so, for what reason? ____

Was it helpful? ___Yes ___No Counselor's Name: ________________

Occupation: ____ Years: ________

Place of Employment: ____

How much do you enjoy your work? __________________________________

Highest Level of Education: ____

Primary Care Physician: ____

Date of last full examination: ____

List any significant medical problems: ________________________________

____

List any currently prescribed medications (and reason for taking):

____

____

____

Have you ever had what one might consider a "nervous breakdown?"

___Yes (When?) ____________ ___No

List any hospitalizations for emotional or psychological issues:

____

Are you aware of mental illness in your family history? _________________

____

____

Have you ever considered suicide? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No

Are you currently having any suicidal thoughts? ___Yes ___No

Do you currently use any of the following substances?

Alcohol ___Yes ___No If yes, how much/day? ____________

Cigarettes ___Yes ___No If yes, how much/day? ____________

Other chemical substances (marijuana, cocaine, herbs, etc): ____________

________________________________ If so, how much/day? _____________

Caffeine: ___Yes ___No If yes, how much/day? ____________

How much sleep do you routinely get each night? _____________________

Do you have any sexual concerns? ___Yes ___No

If yes, please describe: ____

Present Relationship Status: (Check one)

___Single ___Married (# of years) ___ ___Divorced (# of years?) ___

___Separated (how long?) ___ ___Widowed (how long?) ___

Briefly describe your current relationship (if applicable): ________________

____

____

Past and Present Spouse/Partner Information:

Names: Ages: # of Years together: Occupation:

Children:

Names: Ages: Name of Co-parent:

Your Parents:

Names: Ages: Marital Status: Deceased?

Briefly describe your relationship with each parent: ____________________

____

____

____

Siblings:

Names: Ages: Marital Status: Occupation:

Do you have a religious affiliation? _____ If so, describe: _______________

How important is a spiritual perspective to you in doing therapy?

____

For what areas of your life are you seeking assistance?

(ie – marital, relationship, family, work, grief, depression, etc)

1. ____

2. ____

3. ____

Briefly describe what you hope to accomplish with counseling.

____

____

____

____

Please Mark All Symptoms That Apply

- ❑ 1. Depressed Mood
- ❑ 2. Lost interest in most activities
- ❑ 3. Increased appetite
- ❑ 4. Decreased appetite
- ❑ 5. Weight Gain
- ❑ 6. Weight Loss
- ❑ 7. Difficulty going to sleep
- ❑ 8. Difficulty staying asleep
- ❑ 9. Fatigue, loss of energy
- ❑ 10. Feelings of worthlessness
- ❑ 11. Inappropriate guilt
- ❑ 12. Difficulty concentrating
- ❑ 13. Preoccupation with death
- ❑ 14. Suicidal thoughts
- ❑ 15. Excessive or uncontrollable worry
- ❑ 16. Restlessness
- ❑ 17. Irritable
- ❑ 18. Decreased need for sleep
- ❑ 19. Increased talking
- ❑ 20. Racing thoughts
- ❑ 21. Distractible
- ❑ 22. Elevated mood
- ❑ 23. Engaging in risky, pleasurable activities
- ❑ 24. Mood swings
- ❑ 25. Feelings of panic
- ❑ 26. Pounding heart, chest pains, shaking
- ❑ 27. Shortness of breath, dizziness, sweating
- ❑ 28. Recurrent undesirable thoughts
- ❑ 29. Repetitive behaviors (hand washing, checking) or mental acts (counting etc)
- ❑ 30. Nausea or abdominal stress
- ❑ 31. Fear of losing control
- ❑ 32. Fear of dying
- ❑ 33. Recurrent intrusive memories
- ❑ 34. Flashbacks
- ❑ 35. Efforts to avoid memories
- ❑ 36. Fear of social situations
- ❑ 37. Alcohol problems
- ❑ 38. Drug use problems
- ❑ 39. Compulsive dieting
- ❑ 40. Vomiting, use of laxatives
- ❑ 41. Marital problems
- ❑ 42. Sexual problems
- ❑ 43. Impulsive
- ❑ 44. Overwhelmed
- ❑ 45. Angry
- ❑ 46. Easily upset, on edge
- ❑ 47. Careless, forgetful, easily, distracted, difficulty organizing, loses things