Shannon Healy M.A., LMHC

Licensed Mental Health Counselor MH 10647

549 N Wymore Road, Suite 110-A Maitland, FL 32751
Tel: 321-436-4887 E-mail: shannon@healylmhc.com

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Age: _____ Date of Birth: _____

Home Address: _____

Mailing Address (if different than Home): _____

Email Address: _____ Best Contact Phone Number: _____

Where is it okay to leave a message for you?_____ Voice message? □ Yes □ No Text? □Yes □No

Emergency Contact Name _____ Relationship _____ Phone_____

Identities (Ethnicity, Sexual Orientation, Religious) _____

_____

Referred by: □ Self □ Friend □ Family Member □ Other Name (optional)_____

May I let this person know you attended this session? □ Yes □ No

Please summarize the specific concerns that brought you to counseling? _____

_____

_____

How long has this been a concern? _____

How did you decide to address this issue in counseling now? _____

_____

When our work together has been successful, what differences will you notice in yourself? What are your expectations of counseling? _____

_____

How hopeful are you that counseling will be successful/helpful?

□ Not at all □ A little □ Moderately □ Extremely

Please list your strengths and the qualities that you admire about yourself: _____

_____

_____

Have you participated in counseling before: □ Yes □ No If yes, how would you describe this experience?

_____

_____

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RELATIONAL/ SUPPORT HISTORY:

Relationship Status (circle current, check all that apply): □ Single □ In Committed Relationship

□ Cohabitating/Unmarried □ Partnered/Married □ Separated □ Divorced □ Widowed

If you are in a romantic relationship, how long have you been in this relationship? _____

Are you satisfied with your current romantic relationship? □ Yes □ No □ I Don't Know

Do you feel supported by your partner/spouse? □ Yes □ No □ I Don't Know

How would you rate the quality of your friendships? □ Poor □ Fair □ Good □ Excellent

Do you feel that you currently have good social support? □ Yes □ No Explain: _____

_____

ACADEMIC/ WORK:

Place of employment: _____ Position: _____

Are you satisfied with your job? □ Yes □ No □ I Don't Know

Highest Educational Degree: _____ Major or Area of Study: _____

Are you a student? □ Yes □ No If yes, where are you studying: _____

FAMILY BACKGROUND: **Family Status: □ Intact □ Divorced □ Separated □ Other**

Do you have any children? □ Yes □ No If yes, how many? _____

Do you have any siblings? □ Yes □ No If yes, how many? _____

Please list the members currently living in your household:

First Name	Age	Relation to you	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people significant to you (Please specify relationship – partner, friend, sibling, parent, aunt, uncle, etc.):

_____

_____

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How much conflict do you currently experience with your family (whether living with you or not)?

□ None □ Very Little □ Moderate □ Strong □ Extreme

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

PHYSICAL HEALTH:

How would you rate your physical health? □ Poor □ Fair □ Good □ Excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Do you have a disability? No Yes Specify: _____

Please list any medications you are **currently** taking:

Medication	Reason	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you having any problems with your **sleep habits**? □ No □ Yes

Are you having any difficulty with **appetite or eating habits**? □ No □ Yes

Have you had a **significant weight change** in the last 2 months? □ No □ Yes

Do you have any problems or worries about **sexual functioning?** □ No □ Yes

How many times per week do you **exercise?** _____ Type? _____ Duration? _____

MENTAL HEALTH

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? □ No □ Yes

If yes, where: _____ When: _____ Duration: _____

What was the focus of the psychiatric treatment? _____

Previous or Current Diagnoses_____

Have you **ever** been prescribed psychiatric medications? □ No □ Yes

What medications and for what reason? _____

_____

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Current Suicidal Thoughts? □ Never □ Rarely □ Sometimes □ Often

Past Suicidal Thoughts? □ Never □ Rarely □ Sometimes □ Often

Suicide Attempts? □No □ Yes If Yes, when?_____

What were the circumstances? _____

Incidents of Self Harm? □No □ Yes If Yes, please describe _____

Current Thoughts of Harming Others? □ Never □ Rarely □ Sometimes □ Often

Past Thoughts of Harming Others? □ Never □ Rarely □ Sometimes □ Often

Have you ever been hospitalized for psychological reasons? □ No □ Yes If Yes, when? _____

What were the circumstances? _____

Please check any of the following concerns and symptoms that apply to you. Place two check marks by (or underline, or circle) the items that are of most concern to you.

- □ Relationship with Partner/Spouse
- □ Relationship with Family Members
- □ Dating/Romantic Relationships
- □ Relationship with Friends/Roommate
- □ Relationship with Employer
- □ Death or Loss of Significant Person
- □ Spiritual Concerns
- □ Family of Origin (childhood) Concerns
- □ Sexual Concerns
- □ Medical Concerns
- □ Ethnic/Racial Concerns
- □ Education/Employment/Career plans
- □ Financial Concerns
- □ Legal Concerns
- □ Parenting Concerns
- □ Concerns about alcohol or drug use
- □ Concerns about Beliefs or Values
- □ Food and Body Image Concerns
- □ Sexual Identity Concerns
- □ Physical Abuse/Assault
- □ Sexual Abuse/Assault
- □ Emotional Abuse
- □ Other Emotional Trauma
- □ Other Physical Trauma
- □ Anger, Irritability
- □ Depression, low mood, sadness, crying
- □ Difficulty Concentrating
- □ Eating Problems –Overeating, Under eating, Bingeing, Purging
- □ Anxiety, Excessive Worry
- □ Fatigue, Low Energy
- □ Fears, Phobias
- □ Headaches
- □ Impulsiveness
- □ Lack of Motivation
- □ Loneliness
- □ Low Motivation
- □ Low Self Esteem
- □ Mood Swings
- □ Obsessions, Compulsions
- □ Panic Attacks
- □ Perfectionism
- □ Procrastination
- □ Restlessness, Racing Thoughts
- □ Self-Harm
- □ Shyness, Social Anxiety
- □ Sleep Difficulties
- □ Stress Management
- □ Suicidal Thoughts