Marian “Micki” O’Brien, LPC-S Date_____

Client Intake Form

Name_____ Age _____ Date of Birth_____

Address_____

Email address _____

Cell Ph#_____ Home/Other Ph # _____

Gender ___ Single ___ Partnered ___ Married ___ Names/ages of Children_____

Employer_____ Work Ph#_____

Job Title/description_____

School Info, if applicable _____

Emergency Contact Person: Name, phone # and relationship to you

_____

Insurance Information, if applicable : Company_____

Member ID#_____ Group# _____

Current Medications and Prescribing Physician (use the included blank page if more room is needed)

_____

_____

_____

Please describe your primary reason for seeking therapy at this time (use blank page below, if needed).

_____

_____

_____

_____

Rate the severity of your current <u>stress</u> on a scale of

0 (none)—-1——2———3———4———5———6———7——8——-9——-10(major)

Rate the severity of your current feelings of <u>anxiety</u> on a scale of

0 (none)—-1——2———3———4———5———6———7——8——-9——-10(major)

Rate the severity of your current feelings of <u>depression</u> on a scale of

0 (none)—-1——2———3———4———5———6———7——8——-9——-10(major)

Please mark any of the following which apply to you at this time.

Mood

___ Anxiety

___ Depression

___ Loss/Grief

___ Suicidal Thoughts: if yes, describe_____

_____

___ Suicide attempts: if yes, describe_____

_____

___ Mood Swings

Substance Use / Abuse

___/___ Alcohol

___/___ Marijuana

___/___ Other Drugs

___/___ Nicotine

___/___ Over-the-Counter products

___/___ Food

___/___ Other _____

Relationship Concerns

___Significant Other/Spouse

___ Parents

___ Siblings

___Children

___ Friends

___Co-worker

___Supervisor

___Other _____

Problematic Conditions

___ Sleeplessness

___ Eating/digestive

___ Headaches

___ Injury

___ Chronic Condition

___ PTSD/trauma

___ ADD/ADHD

___ Addiction: describe_____

___Other: describe_____

Self/Interpersonal Issues

___ Self-Esteem

___ Perfectionism

___ Caretaker/Hero

___ Fears/Worries

___ Anger

___ Child of Alcoholic/Addict

___ Powerlessness

___ Assertiveness

___ Work-related

___ Shyness

___ Trust

___ Intimacy

___ Codependency

___ Loneliness

___ Stress

___ Confidence

___ Other: describe_____

___ Emotional Abuse

___ Physical Abuse

___ Sexual Abuse/Rape

___ Past Abuse of any kind

___ Career/Job

___ Identity

___ Sexual Identity

___ Sexual Concerns

Use the blank page below if add'l room is needed to answer the following:

Past Therapy/Counseling:

Family of Origin: Who is in the family? Where did you grow up? What were/are the dynamics?

Significant Life Events (Positive and Negative):

How have you coped with stressors in your life?

What else would be helpful for me to know:

I, _____, give my "Consent to Treatment"

(print name)

to Marian Micki O'Brien, LPC-S for the purposes of counseling/therapy and am free to end counseling at any time.

_____ _____

(Signature) (Date)