Counseling Ordinary Courage
Live with Meaningful Connection

*Eastlake Ave*
*Seattle, WA 98102*

**Date:** / /

# New Client Intake

***Please read the following questions and answer them as honestly as you can. Information and responses will be kept confidential within Counseling Ordinary Courage, LLC. I appreciate and respect your willingness to be vulnerable in this process, and I look forward to getting to know you.***

## Contact Information

| **First Name:** | **MI:** | **Last Name:** |
|---|---|---|
| **Birth Date:** _____/_____/_____ | **Age:** | **Social Security Number:** _____-_____-_____ |

**Address:**

_____
**(Street)** **(City)** **(State/Zip)**

| **Preferred Phone:** | **Alternate Phone:** |
|---|---|
| (_____) _____-_____ | (_____) _____-_____ |

**Email:**

_____
(Please note that email correspondence is not considered to be a confidential medium of communication)

**Please check a preferred method of contact:**
**Text:** ☐ **Email:** ☐ **Phone Call:** ☐

## Emergency Information

| **Emergency Contact:** | **Emergency Contact Phone:** | **Relationship to Emergency Contact:** |
|---|---|---|
| _____ **(First)** **(Last)** | (_____) _____-_____ | _____ |

## Health & Medical Information

**1. Do you have any chronic medical or physical conditions? If yes, what are they and how do they affect you?**

_____

_____

**2. Are you currently taking any prescribed or non-prescribed psychiatric medication? If yes, please list and include dosage:**

_____

_____

_____

**3. Have you ever been prescribed psychiatric medication? If yes, please list and include dates:**

_____

_____

_____

_____

**4. Have you previously received any type of mental health services? If yes, please list previous therapist/practitioner(s):**

_____

**5. Have you or someone you are close to ever been concerned about your alcohol or drug usage?**
**Yes_____ No_____**

**6. How many times per week do you generally exercise?**

_____

**7. Please list any specific health problems or disabilities you are currently experiencing:**

_____

**8. Are you experiencing any sleep problems? If so, please explain:**

_____

_____

**9. Approximately how many hours of sleep do you get per night?**

_____

**10. Please list any difficulties you experience with appetite or eating patterns:**

_____

_____

**11. How often do you drink caffeinated beverages?**
**□ Daily □ Weekly □ Monthly □ Infrequently□ Never**

**12. How often do you drink alcohol?**
**□ Daily**
**□ Weekly**
**□ Monthly**
**□ Infrequently**
**□ Never**

**13. How often do you use tobacco or nicotine products?**
**□ Daily**
**□ Weekly**
**□ Monthly**
**□ Infrequently**
**□ Never**

**14. How often do you engage recreational drug use?**
**□ Daily**
**□ Weekly**
**□ Monthly**
**□ Infrequently**
**□ Never**

## RELATIONSHIP INFORMATION

**1. Relationship status/Name of partner(s):**

_____

**2. How long have you been in your current relationship state?**

_____

**3. Please list any children/age:**

_____

_____

**4. Please indicate your biological sex:**

**Male** _____

**Female** _____

**5. Please indicate your gender identification:**

_____

**6. In your own words, please describe your sexual orientation:**

_____

**7. Were your parents separated or divorced during the first 18 years of your life?**
**Yes** _____ **No** _____

**8. Please check any areas in which you have experienced abuse in any past or current relationships:**
**Emotional□ Verbal□ Physical□ Other** _____

**9. Has anyone you've known struggled with chronic illness?**
**Yes**_____ **No**_____

**10. Has anyone you've known struggled with drugs or alcohol use? Yes**_____ **No**_____

**11. Has anyone you've known talked about or tried to commit suicide? Yes**_____ **No**_____

## CURRENT INFORMATION

**1. If you are currently employed, please list your occupation:**

_____

**2. Please list your educational background and indicate if you are currently enrolled in school:**

_____

**3. Who do you currently live with? (i.e. Alone, Roommates, Family)**

_____

**4. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:**

_____

| **5. Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all** | **Several days** | **Over half the days** | **Nearly every day** |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | □ | □ | □ | □ |
| Poor appetite or overeating | □ | □ | □ | □ |
| Feeling tired or having little energy | □ | □ | □ | □ |
| Feeling bad about yourself | □ | □ | □ | □ |
| Trouble concentrating on things, such as reading | □ | □ | □ | □ |
| Becoming easily annoyed or irritated | □ | □ | □ | □ |
| Thoughts that you would be better off dead or hurting yourself | □ | □ | □ | □ |
| Not being able to stop or control worrying | □ | □ | □ | □ |
| Trouble falling/staying asleep, sleeping too much | □ | □ | □ | □ |

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## COUNSELING INFORMATION

**How did you hear about this office or who referred you?**

**My primary way I cope with problems is:**

| **The worst thing about my life is:** | **The best thing about my life is:** |
|---|---|

**Please list any significant life experiences or events you have had that have had an important effect on making you the person you are today (these could be positive or difficult and traumatic experiences):**

**The reason(s) I am seeking counseling is:**

**What I would specifically like to accomplish in working with you is:**

**What I want most from counseling is:**

**What other information would be of value to me in helping you?**