La Fleur Counseling, LLC
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Client Intake Form

Name_____ Age_____ Date of Birth_____

Address_____

Cell Phone_____ Is it okay to leave a message? Y / N

Email_____ Is it okay to contact you via email? Y / N

Preferred way to contact you?_____

How did you hear about my services?_____

Physician's Name_____

Name of Employer or School_____ Grade_____

Gender Identification _____Sexual Orientation_____ Sexually Active Y / N

Relationship Status ___Single ___Married ___Partnered ___ Separated ___Divorced ___Widowed

If under 18, relationship with parents: ___OK ___Good ___Challenging ___Would like to improve it

If under 18, Parent's Relationship status ___ Single ___Dating ___Partnered ___Divorced ___Married

Who are the people you live with? Please provide name, age, and relationship.

Name	Relationship	Age	How would you describe the relationship?

Mental Health Information

Have you ever had counseling before? Y / N If yes, please describe the reason, the therapists name, approximate dates and whether the counseling was helpful.

_____

_____

Briefly describe what brings you to counseling today?

_____

_____

What goals would you like to achieve from counseling?

_____

_____

Medication Information

Name of Medication Dosage Date Started Prescribing Physician

_____

_____

_____

Please check any of the following issues that are a concern for you.

	Insomnia		School or Work Issues		Suicidal Thoughts/Attempts
	Depressed Mood		Relationship Issues		Hallucinations
	Mood Swings		Sexual Issues		Grief / Loss
	Anxiety		Gender Identity		Legal Problems
	Panic Attacks		Self Esteem		Physical Health Problems
	Anger		Repetitive Thoughts		Urges to harm Others
	Disordered Eating		Repetitive Behaviors		Stress
	Drug or Alcohol Abuse		Cutting / Self Harming		Chronic Pain
	Emotional Abuse		Sexual Abuse		Physical Abuse
	Financial Concerns		Blended Family Concerns		PTSD

Have you ever been hospitalized or gone to the emergency room? Y / N If yes, please describe:

Date(s) of Hospitalization What Facility Reason for Hospitalization

_____

_____

Please List any diagnosis you have received in the past

Diagnosis Date of Diagnosis Who made this Diagnosis?

_____

_____

_____

Who in your immediate family has experienced the following?

M (mom) **D** (dad) **S** (sibling) **GP** (Grandparent)

	Drug / Alcohol Abuse		Prescription Drug Abuse		Disordered Eating
	Depression / Anxiety		Suicide Attempts		Mental Health Issues
	Mood Swings		Self-Harming Behavior		Anger Problems

Have you ever experienced any traumas or losses in your life? Y / N If yes, please describe briefly:

_____

_____

Who do you turn to for support?_____

Substance Use History: Have you **ever** used the following?

		How Often?	How Much?	Date of Last Use?
	Alcohol			
	Marijuana / Dabs			
	Cocaine / Crack / Meth			
	Prescription Pain Meds			
	Xanax / Klonopin			
	Heroin			
	Hallucinogens			
	Ecstasy / Molly			
	Energy Drinks			
	Spice			
	DXM			
	Ritalin / Adderall			
	Nicotine			
	Other:			

Have you ever experienced any consequences (Family, Physical, Legal, Work, School) due to your use? Y / N

_____

Have you ever had drug / alcohol counseling? Y / N If yes, when and where?

_____

Has anyone ever thought you had a problem with substances? Y / N Who?_____

*****Emergency Contact Numbers*****

Name:_____ Relationship_____ Phone_____

Name:_____Relationship_____Phone_____

Client Signature:_____ Date:_____

Client / Parent Signature:_____Date:_____