**CLIENT INTAKE FORM**

**Mountain Rose Counseling**

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Date of ﬁrst appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is conﬁdential.

Referred by:

Medical Provider: Insurance Provider: My Website:

PsychologyToday

Friend/Family: Other:

Have you previously received any type of mental health services?

Yes

No

If yes, which of the following: Psychotherapy Medication

Outpatient Hospitalizations

Inpatient Hospitalization

If yes, please provide:

Name of provider or facility: Location:

Dates of treatment:

Reason for treatment:

Brieﬂy, what brings you in today

When did your problem ﬁrst start? Within the last:

30 days

6--12 months

2 years

During adolescence

During childhood

What areas of your life have been aﬀected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

Yes

No

If yes, for approximately how long?

Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes

No

If yes, when did you begin experiencing this?

Please describe any major losses or traumas you have experienced:

What signiﬁcant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

**Family History**

Where were you born?

Where did you grow up?

City Suburbs Country

Please list your parents and siblings. Please use additional space on the back if needed

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| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Where do they live now?** | **If deceased, age and cause of death** |
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Who did you live with while growing up?

Mother's occupation:

Father's occupation?

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

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| --- | --- | --- |
| **Condition** | **Please circle** | **List Family Member** |
| Alcohol/Substance Abuse | yes/no |  |
| Anxiety | yes/no |  |
| Depression | yes/no |  |
| Domestic Violence | yes/no |  |
| Sexual Abuse | yes/no |  |
| Eating Disorders | yes/no |  |
| Obesity | yes/no |  |
| Obsessive Compulsive Disorder | yes/no |  |
| Schizophrenia | yes/no |  |
| Suicide Attempts | yes/no |  |
| Other diagnosed mental health condition? | yes/no : which was--- |  |

Marital Status:

Never Married Domestic Partner Married Separated

Divorced -- For how long?

Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

On a scale of 1-10 (best), how would you rate your relationship?

Are you currently in a romantic relationship?

Yes -- How long? No

On a scale of 1-10 (best), how would you rate your relationship?

Please list any children, their names, and ages:

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| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Name of other parent** | **If deceased, age and cause of death** |
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**Physical Health**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for oﬀ-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical proﬁle, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

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| --- | --- | --- | --- |
| **Medication/Supplement** | **Dosage** | **Condition** | **NameBegan/Stopped** |
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Prescribing provider and contact information:

Name:

Specialty:

Facility:

Phone, email, or Fax:

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good

Very Good

Please list any speciﬁc health problems you are currently experiencing:

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good

Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep Staying asleep Awakening early Sleep apnea

Please list any other speciﬁc sleep problems you are currently experiencing:

How many times per week do you generally exercise? What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

**Additional Information**

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you ﬁnd particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?