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**Client Intake Form**

*Please provide the following information and answer the questions below. Please note:*

*Information you provide here is protected as confidential information.*

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*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Last) (First) (Middle Initial)*

*Birth Date: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_*

*Address:*

*(Street and Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(City) (State) (Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? □Yes □No*

*Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we leave a message? □Yes □No*

*Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? □Yes □No*

*E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we email you? □Yes □No*

*\*Please note: Email correspondence is not considered to be a confidential medium of communication.*

*How did you find me?*

*Referred by (if any):*

*Preferred Pronouns:*

*How do you self-identify in terms of biological sex/gender/sexual orientation?*

*How do you self-identify in terms of race/ethnicity/culture?*

*Is this identity impacting your situation or the issues that are bringing you into therapy? If so, how?*

***RELATIONSHIP STATUS*** *(partnered, married, single, etc.):*

*If in a romantic relationship,, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_\_\_*

*Please list any children and their ages:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Have you previously received any type of mental health services (psychotherapy, psychiatric*

*services, etc.)?*

*If yes, previous therapist/practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*What did you find helpful?*

*What did you not find helpful?*

*Are you currently taking any prescription medication?*

*Please list:*

*Have you ever been prescribed psychiatric medication?*

*If yes, please list and provide dates:*

***GENERAL HEALTH AND MENTAL HEALTH INFORMATION***

*Please list the name and number of your* ***General Practitioner****:*

*1. How would you rate your current physical health? (Please circle)*

*Poor Unsatisfactory Satisfactory Good Very good*

*Please list any specific health problems you are currently experiencing:*

*2. How would you rate your current sleeping habits?*

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

*3. How many times per week do you generally exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*What types of exercise to you participate in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*4. Please list any difficulties you experience with your appetite or eating patterns.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*5. Are you currently experiencing overwhelming sadness, grief or depression?*

*□ No*

*□ Yes*

*If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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

*□ No*

*□ Yes*

*If yes, when did you begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*7. Are you currently experiencing any chronic pain?*

*□ No*

*□ Yes*

*If yes, please describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*8. Do you drink alcohol more than once a week? □ No □ Yes*

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

*10. Have you or anyone in your life been concerned with your use of either one?*

*11. Have you or a loved one experienced any dramatic changes or event recently?*

*12. Is there anything else you think I should know?*

***FAMILY MENTAL HEALTH HISTORY:***

*In the section below identify if there is a family history of any of the following. Please Circle and List Family Member:*

*Alcohol/Substance Abuse yes/no*

*Anxiety yes/no*

*Depression yes/no*

*Domestic Violence yes/no*

*Eating Disorders yes/no*

*Obesity yes/no*

*Obsessive Compulsive Behavior yes/no*

*Schizophrenia yes/no*

*Suicide Attempts yes/no*

***ADDITIONAL INFORMATION:***

*1. Are you currently employed? □ No □ Yes*

*If yes, name and address of your employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Do you enjoy your work? Is there anything stressful about your current work?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*2. Do you consider yourself to be spiritual or religious? □ No □ Yes*

*If yes, describe your faith or belief:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*3. What do you consider to be some of your strengths?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*4. What do you consider to be some of your weaknesses?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*5. What would you like to accomplish out of your time in therapy?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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