Kim Smith Iverson Counseling, LLC
New Client Intake Form

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Date_____

First Name_____ Middle_____ Last Name_____

DOB_____ Gender_____ Marital Status_____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____ Work_____

Best Time to Call_____ May I leave a message? Yes ____ No ____

If so, where do you prefer messages to be left? Home Cell Work

Who is responsible for your bill? _____

Responsible party's address (if not your own) _____

Employer_____ How long? _____ Position_____

Emergency Contact Name & Number_____

Reason seeking counseling_____

_____

Medical Information

Family Physician_____ Psychiatrist / Psychologist_____

Are you currently taking any prescription drugs for any reason? Yes / No

If yes, please provide the following information on your prescriptions:

Drug Name_____ Dosage_____ Reason for taking _____

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Drug Name_____ Dosage_____ Reason for taking _____

Who prescribed your medications and how often do you see this doctor? _____

Describe your physical health: Excellent ____ Good ____ Adequate ____ Poor ____

Have you ever been hospitalized or a patient of a treatment facility for mental, emotional or addiction issues? Yes / No If yes, for what reason? _____

How long where you in treatment? _____ Treatment date_____

Name of facility_____

Did you continue with outpatient counseling after release? Yes____ No____

Name of counselor_____

Any family history of mental illness? Yes / No If yes, explain_____

_____

Counseling History

Have you ever received counseling services before? Yes / No If yes, how long? _____

For what reason did you seek counseling? _____

Do you have a clinical diagnosis? If yes, explain: _____

Who was the counselor? _____ Did you find it beneficial? _____

If yes, how was it beneficial? _____

If no, what could have been done better? _____

Are you involved in any other marriage counseling / family counseling / support group? Yes / No

If yes, please describe_____

What do you expect to gain from counseling? _____

_____

_____

What is the nature of the problem as you see it? _____

_____

_____

_____

Who referred you to my counseling practice? _____

What is your religious preference? _____ If any, do you attend church? _____

How strong is the influence of church in your life? _____

Would you like your religion / faith incorporated into our counseling? _____

_____

Impact of Life Circumstances

Please circle any **LOSSES** that you have experienced:

Death of: Spouse / Child / Father / Mother / Sibling / Grandparent / Friend / Significant Other,

Divorce, Separation, Broken Engagement, Suicide, Miscarriage, Abortion, Infertility, Bankruptcy,

Homelessness, Career / Job, Other Losses: _____

Please circle any **VICTIMIZATIONS** that you have experienced or been involved with:

Child abuse: Physical / Emotional / Sexual / Incest

Spouse abuse: Physical / Emotional / Sexual Was this done to you, or by you? _____

Abandonment / Rape / Robbery / Assault / Suicide attempt / Auto or industrial accident/ Major illness

Surgery / Physical disability / Alienation / Discrimination / Other Victimizations: _____

Please circle any **PROBLEMS** that concern you now:

Relationship(s) with: Spouse / Children / Parents / In-laws / Co-workers / Friends / Teachers

Alcohol, Illegal drugs, Prescription drugs, Binge eating, Excessive Dieting or exercise, Shopping, Work,

Procrastination, Communication, Depression, Anger, Grief, Gender identity, Sex, Career, Loneliness,

Mood swings, Self-esteem, Codependency, Stress, Fear, Anxiety, Feelings about church or God,

Other Problems: _____

_____

Intense Emotional Distress

Please explain any current situation you are having or contemplating:

Suicidal thoughts, plans, attempts: _____

Homicidal thoughts, plans, attempts: _____

Desire to cause pain to self or others: _____

Too depressed to care for self / family: _____

By signing below, I affirm that the information given on this intake form is true and complete.

_____ _____

Client or Custodial Parent / Guardian for Minor Date