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Client Intake Form - Adult

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.

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Identified Gender _____ Preferred Pronouns _____

Address _____

Contact Phone Number(s) Cell _____

Other _____

Contact E-Mail Address _____

Status: Single Married Partnered Div. Widowed Other

Number of children _____ Ages of children _____

Occupation _____ Employer _____

Ethnicity _____ Religion _____

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Are you currently working with a physician, psychiatrist, or other healthcare provider?

Name & Practice Name _____

Would you like me to coordinate with this provider? YES NO

Client Health History

History of Mental Health Services: _____

History of Psychiatric medication YES NO

List: _____

Current Medications YES NO

List: _____

Previous Mental Health diagnosis YES NO

List: _____

Relevant Medical Diagnosis: _____

History of substance use/abuse? YES NO Current? YES NO

Generally, how do you sleep? Check all that apply:

Great! *OK* *Hard to fall asleep* *Hard to wake up* *Wake up frequently at night*

Generally, how often are you active (exercise, play, garden, etc.)? Check all that apply:

Hardly ever *1x per week* *2-3 times per week* *4x or more per week* *Daily*

Please list your current hobbies _____

Are others concerned about the amount of alcohol you drink / your recreational drug use? Yes No

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, when? _____

Have you ever made a plan to commit suicide or attempted suicide? Yes No

If yes, when? _____

Do you currently have thoughts of ending your life, or acting recklessly in a way that would kill you? YES NO

Please list additional information you would like me to know

Client Interest in Counseling Services

Briefly Describe...

What brought you to counseling today?

What goals do you have for counseling?

Please check any of the following that currently apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Money Issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Abuse | <input type="checkbox"/> Worry/Fear |
| <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Cutting/Self-Harm | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Grief and Loss |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Worry/Fear | <input type="checkbox"/> Health Concern |
| <input type="checkbox"/> Self-Control | <input type="checkbox"/> Drug/Alcohol Use | <input type="checkbox"/> Decision Making |
| <input type="checkbox"/> Strained relationship(s) | | |

Other: _____

What do you consider to be your strengths?

Thank You.