Julie S. Cake, MA, LHMC
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(206) 920-1448
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CONFIDENTIAL CLIENT INTAKE FORM

Contact Information

Name: ______________________________ Date of Birth: ________________________

Address: ____

City: _______________________________ State: ____________ Zip: _____________

Home Phone: _________________________ May I leave a message? ________________

Work/Cell Phone: _____________________ May I leave a message? ________________

E-mail: _____________________________ May I contact you by email? _____________

Employer/School: _____________________ Occupation/Studying: _________________

Emergency Contact: ___________________ Phone: ___________ Relationship: ______

Family Information

Marital Status: Single Engaged Married Divorced Separated
Living Together Remarried Widowed

Spouse/Partner Name: ____

Names and ages of children: ____

Are your parents living? ____

Names and ages of siblings: ____

Do any of your relatives have a history of mental illness?______________________________

If yes, please explain:____

____

Counseling Goals

Reasons for seeking help at this time:____

____

____

How have these concerns evolved over time?_______________________________________

____

____

What are your goals for our counseling work?______________________________________

____

____

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Health History

Please indicate your major stressors over the last 12 months:

___ Serious illness or injury
___ Death of a close friend or family member
___ Job change/other transition
___ Major illness in family
___ Gain of a new family member
___ Relationship issues /divorce/separation

Other (please elaborate): ____

____

Have you ever received psychological or psychiatric counseling before? __ Yes __ No

When? From Whom? Purpose? Results?

____

____

Are you currently taking or have you ever been prescribed any medications, herbs or supplements for depression or any other mental health condition? __ Yes __ No

When? Prescribing Clinician? What medication? For What? Results?

____

____

Are you currently taking any medications? __ Yes __ No

Please describe: ____

____

Have you ever been hospitalized for a psychiatric or emotional health reason? __ Yes __ No

When? Where? For What Reason? Outcome?

____

____

Have you ever been in a drug, alcohol or other treatment program? __ Yes __ No

When? Where? For What Reason? Outcome?

____

____

Do you currently drink alcohol? __ Yes __ No

How much/how often: ____

Do you currently use recreational drugs? __ Yes __ No

How much/how often: ____

Do you feel you have a problem with alcohol or drugs? __ Yes __ No

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Overall physical condition: ___ Very Good ___ Good ___ Average ___ Poor

Recent weight gain or loss: ____

Physician's name, address and phone number: ____

____

List any surgeries, accidents or serious illnesses and dates: __________________________

____

Have you ever been hospitalized in the last year for any reason? __ Yes __ No

When? Where? For What Reason? Outcome?

____

____

Have you ever attempted or considered suicide? ___ Yes ___ No

If yes, please provide some details: ____

____

____

Do you or have you practiced in cutting? ___ Yes ___ No

If yes, please provide any comments or thoughts: _______________________________________

____

____

How significant a role does spirituality play in your life?

___ None ___ Somewhat important ___ Significant ___ Very significant

Is there anything else you think I should know about prior to our beginning your treatment?

____

____

____

____

How did you find out about my services? ____