Intake Form

My Path Unfolding, LLC / Kristen R. Weick MA, LMHC, NCC

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321-209-4311 / mypathunfolding@gmail.com / http://www.mypathunfolding.com

Date: _____

Client's legal name: _____

Nickname or preferred name: _____

**If form filled out in part or completely by parent, guardian, or agent, please write name and relationship to client: _____

What gender pronouns do you use? _____

Cell Phone Number: _____ May I leave a message? _____

Street Address: _____

_____

E-mail Address: _____ May I e-mail you? _____

Date of Birth: _____ Age: _____

Relationship Status: _____

Please list any children you have and their ages: _____

What is your current employment and/or school situation? How satisfied are you with either or both of these things? _____

_____

What is your current housing situation? With whom do you live? Are you satisfied with your housing situation? _____

_____

Do you identify with a particular race, culture, and/or ethnicity? Please describe:

_____ How important is it to you? _____

Do you identify with a particular religion, spirituality, or no faith tradition? Please describe:

_____ How important is it to you? _____

How do you define your sexual orientation? _____

_____

How do you define your gender identity and expression? _____

_____

How would you describe your quality of life right now? _____

_____

Do you have any previous mental health diagnosis (if so, what age?), or do you feel as though you may need assessment for a mental health issue? _____

_____

_____

Are you currently taking any prescription medications, specifically, medications to help with mental health issues? _____

Have you taken mental health related prescription medications in the past that you are no longer taking? If yes, why are you no longer taking them? _____

_____

Is there a history of mental illness in any of your family members? _____

_____

Have you ever seen a counselor, been part of a support or counseling group, or been hospitalized for psychological reasons before? If yes, please describe, and what are your thoughts on these experiences? _____

_____

Do you have any past or current substance abuse issues? _____

_____

Do you feel you have any difficulties with your appetite, eating, or exercise patterns? _____

_____

Have you thought of killing yourself or attempted to kill yourself **in the past**? If yes, please describe: _____

Are you **currently** having thoughts of killing yourself? If yes, do you have a plan of how you will do it and the means to do it? _____

Is there a history of suicide in your family or close personal relations? _____

_____

Do you have any current or past significant physical health problems? _____

_____

Have you experienced emotional, physical, or sexual abuse **in the past**? You do not need to go into detail if you are uncomfortable, but it helps the counselor to generally be aware of things you experienced. _____

_____

Are you **currently** experiencing any form of abuse? If yes, please write only what you are comfortable mentioning. _____

_____

Have you experienced any significant traumatic events in your life? Again, just give as much information as you are comfortable with at this time. _____

_____

Have you ever served in the military? If yes, please describe: _____

_____

Have you ever been convicted of a crime? _____ If yes, please describe convictions and years: _____

Have you spent time in jail or prison? _____

Are you currently required by a court of law to receive counseling? _____

What are your current life stressors? _____

_____

What are some initial goals you have in attending counseling and/or your reason(s) for seeking counseling at this time? _____

_____

_____

Is there anything else I should know about you? _____

_____

_____

How did you hear about My Path Unfolding, LLC / Kristen R. Weick MA, LMHC, NCC?

_____

Please list the names and phone numbers of your Primary Care Physician and/or Psychiatrist prescribing mental health medications (I will not contact them unless there is a medical emergency or I have your permission via a Release of Information form):

_____

_____

If client is under 18 years old, please list parent or guardian information:

Name: _____

Cell Phone Number: _____

Street Address: _____

E-mail Address: _____

Relationship to Client: _____

Emergency Contact (I may contact this person in the event of a medical emergency):

Name: _____

Cell Phone Number: _____

Street Address: _____

E-mail Address: _____

Relationship to Client: _____

Please sign below if you feel you have filled out this form truthfully and to the best of your ability at this time:

_____

Print Full Legal Client or Guardian Name

_____

Client or Guardian Signature Date

_____

Minor's Printed Full Legal Name (If Guardian Signed Above)