Willow Creek Counseling Center, LLC 859-554-0740 1050 Chinoe Rd. Suite 203 Lexington, KY 40502

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any questions you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?

( ) no

( ) yes, with (previous therapist's name)_____________________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: ____

Prescribed by: ____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? ____ Are you currently seeing more than one medical health specialist? ( ) yes ( ) no If yes, please list:

____

When was your last physical? ____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: ____

____

Are you currently on medication to manage a physical health concern? If yes, please list:

____

____ Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) other

____

How many times per week do you exercise? _______________

Approximately how long each time? ______________________

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

____

How often do you engage recreational drug use?

( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Please explain:____

Have you participated in or have thoughts of self harm?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Please explain:____

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Please explain:____

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? ________________________ On a scale of 1-10 (10 being of highest quality), how would you rate your current relationship?

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: ____

____

____

Have you experienced any of the following within the last four weeks?

Extreme depressed mood	Yes / No

Dramatic mood swings	Yes / No

Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your current employer/position? ________________________________

If yes, are you happy with your current position? _______________________________

Please list any work-related stressors, if any ______________________________________
____
____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths? ____________________________________

____

____

What do you like most about yourself?

____

____

____

What are effective coping strategies that you have learned?

____

____

What are your goals for therapy? ____

____

____

____

New Adult Client General Information Sheet

Referred by ____________________

Full Name

____

Street Address

____

City/State/Zip

____

Primary Phone Number _________________________ May we leave a message Y/N

Email ____

Date of Birth ___/___/___ Age _______ Gender Male Female

Highest Grade Completed ________

Ethnicity (optional) _______________

Employer ________________________ Position ______ For how long? _________

Emergency Contact Info

Name ____

Address ____

Primary Phone Number ___________________________

Email ____