Kaye Bradley Williams, LMFT
Client Intake Form

Thank you for filling this out. Please understand that ALL information is kept CONFIDENTIAL.

Name:_____Date:_____

Date of Birth: _____ Age: _____Male_____ Female_____

Address:

_____

_____ZIP Code: _____

E Mail_____

Phone: (Home) _____(Cell) _____ (Work) _____

Do I have permission to leave messages on your phone/ voice mail? YES____ NO____

If so, which number is best to reach you? Home_____ Cell_____ Work_____

Do I have permission to contact you via email concerning appointments? YES_____ NO _____

Do I have permission to contact you via text concerning appointments? YES_____ NO_____

Person to contact in case of an emergency: _____

Address: _____

Phone: _____Relationship:_____

Are you over 18? ____YES ____NO Do you have a court appointed guardian or conservator? If so, please provide their name and contact number:

_____

Present Marital/ Relationship status:

_____ Single/Never married _____ Married (# of years) _____ _____ Divorced (how long?)_____

_____ Separated (how long?) _____ _____ Widowed (how long?)_____ _____Engaged

_____ Co-habitating (living with partner, how long?)_____ _____Other

History of Marriages or Significant Relationships (beginning with the first):

1: Beginning date: _____Ending Date: _____With whom?:_____

How long married/ together? _____Children and Ages_____

2: Beginning date: _____Ending Date: _____With Whom?:_____

How long married/ together? _____ Children and Ages: _____

3: Beginning date: _____Ending Date:_____With Whom?:_____

How long married/ together? _____ Children and Ages:_____

List the names and ages of all people currently living in your home:

Name	Age	Relationship	Occupation

Who has custody of the minor children living in your home? _____

(Please provide applicable court approved parenting plan if I am seeing a minor for individual or family therapy. This can be obtained at the County Clerk's office.)

Present Occupation: _____Place of employment: _____

Highest level of Education: (circle one)

Grade/ Middle School High School Some College Bachelor's Degree Master's/Doctorate

Primary Care Physician: _____

Date of last full examination: _____

List any significant medical problems:

_____

_____

Please list any currently prescribed medications related to psychological issues:

_____

_____

Who suggested you contact me? _____

If you found me on the internet, what web site? _____

Have you participated in counseling before? YES/ NO Are you currently in therapy elsewhere? YES/ NO

If so, where/ with whom?

Name _____dates _____

List any previous hospitalizations or intensive treatments for emotional, substance abuse or psychological issues:_____

Have you ever considered suicide? YES____ NO_____ Have you ever attempted suicide? YES____ NO_____
Are you currently having any suicidal thoughts or thoughts of harming yourself or others?
YES_____ NO_____
Are you aware of mental illness in your family history? If so, please list:

Have you ever had legal/ family problems because of drugs or alcohol? YES____ NO____

If yes, please describe_____

Do you drink alcohol? ____YES ____NO If yes, how much and how often? _____

Please list any other chemical substances you use (marijuana, herbal, etc):

_____

Do you smoke? YES____ NO____ If so, how much per day? _____
How much sleep do you routinely get each night? _____
Do you have a religious affiliation? _____ If so, describe_____
How important is a spiritual perspective to you in doing therapy? _____Not _____Some _____Very

Is your family or anyone in your family currently involved with the following agencies? If yes, please explain (i.e. criminal violations, court appearances, custody hearings, civil suits, etc.)

_____

_____

Dept. of Human Services: YES____ NO_____ Probation or Parole: YES_____ NO_____

Attorney:_____

For what areas of your life are you seeking assistance? (i.e. marital, relationship, family, school, work, grief)

_____

_____

_____

What do you hope to accomplish with counseling?

_____

_____

_____

Please check any of the following issues that concern you or your family members:

Mark "X" for self and "O" for others:

___Headaches ___Alcohol Use/ Misuse ___Drug Use ___Sexual problems ___Sleep Related problems ___Eating problems ___Weight Gain ___Weight Loss ___Appetite ___Problems Relaxing ___Work Problems ___Problems with thoughts ___Difficulty Concentrating ___DUI ___Problems at school	___Financial Problems ___Legal Problems ___Marital Problems ___Sexual Abuse ___Relationships ___Children ___Parents ___Other Family Members ___Loss of friend/ family member ___Loneliness ___Physical Abuse ___Emotional Abuse ___Phobias ___Cutting/ Self-harm ___Recurring, intrusive trauma memories	___Anger ___Sadness ___Confusion ___Depression ___Anxiety ___Guilt ___Grief ___Fear/ Panic ___Self-Esteem ___Self-Confidence ___Suicide/ Suicidal Thoughts ___Stealing ___Gambling ___Engaging in risky behaviors

Now CIRCLE the **TWO** causing the most difficulty for you.

Please provide any additional information that you think may be useful to your therapist:

_____
_____
_____
_____
_____

By signing below, I acknowledge receipt and understanding of Practice Policy Information for Kaye Bradley Williams, LMFT.

Signature_____**Today's Date**_____

Name (written) _____