Key Peninsula Counseling Center
8903 Key Peninsula Hwy. N.
Lakebay, WA 98349

(253) 884-3644

Intake Form

Name: ____
Last First Middle Maiden

Nickname: _____________ Date of birth: ____________ Gender: ☐ male ☐ female

Home Phone: (   ) _________________ Work Phone: (   ) _________________

Cell Phone: (   ) ___________________

E-mail: ____

Street: ____

City: _____________________________ State: _____ Zip: ____________

Emergency Contact: ______________________ Phone: (   ) __________________

E-mail: ___________________ Relationship to Client: _______________________

Insurance Information: Co- Pay: $__________________

Insurance Name: __________________ Relationship to Client: __________________

Insured's Group #: __________________ Insured's I.D. Number: ________________

Employer's Name:____

Insurance Plan Name:____

Insured's contact info (if different from Client)

____
Name address City State Zip

Symptom Checklist

Reason for seeking treatment: ____

____

Please check any of the concerns or symptoms listed below that you are currently experiencing:

	Marriage /relationship problems		Verbal /emotional abuse (current or past)
	Difficulty with family		Loss of interest in previous activities
	Difficulty with friends		Recurrent flashbacks
	School problems		Episodes of loss time
	Step-family problems		Trouble with memory
	Divorce issues		Confusion
	Serious physical illness (self or family)		Hyperactivity/ attention problems
	Health concerns (self or family)		Headaches/stomach aches
	Fatigue/ low energy		Sexual problems
	Death of family member/friend		Sexual identity concerns
	Anxiety/worry/nervousness		Feeling of unreality
	Panic attacks		Obsessive thoughts/ excessive fears
	Reluctant to leave home/neighborhood		Unusual thoughts or perceptions
	Perfectionism		Excessive energy
	Guilt/ shame feelings		Poor impulsive decisions or actions
	Trouble sleeping		Difficulty trusting others
	Depressed mood/ sadness		Low self esteem
	Suicidal thoughts		Avoiding conflict
	Self injury		Withdrawn, isolating
	Increase/decrease in eating habits		Shyness/uneasy around others
	Spending habits		Fear of failure
	Concern about current behavior		Fear of disapproval
	Concern about use of alcohol		Loss of hope
	Concern about use of drugs		Physical abuse of others (people /animal)
	Concern about lying/dishonesty		Sexual or porn addiction
	Anger		Difficulty saying no to others
	Irritability		Unable to make independent decisions
	Mood swings		Hallucinations
	Loss of temper		Tearful
	Aggressive / violent behavior		Other: (specify)
	Physical abuse issues (past or present)		

Please rate the overall level of stress that you feel is currently pressing on you, include life changes, work, family, friends and finances. (Circle appropriate number)

1	2	3	4	5
minimal		moderate		extreme

comments:____

____

Please describe how your concerns or symptoms are interfering with:

- Your quality of life and inner well being

- Your relationship

- Your health

- Your work / school

Have you been to counseling or a therapist before? YES ☐ NO ☐

If yes who did you see and for how long? ____

If you have had any previous counseling or therapy, please tell us what you found to be helpful and what you found not to be helpful.

____
____
____
____
____
____

Marital Status
(Check all that apply)

	Single		Divorce in progress		Unmarried but living together
	Widowed		Separated		Divorced
	Legally Married		Annulment		Other:

Do you have children? Yes ☐ No ☐
If so what is their names and ages:____

____

Parental Information

	Parents legally married		Mother has remarried Number of times
	Parents ever been separated		Father has remarried Number of times
	Parents ever been divorced		

Legal information (Current legal status)

Are you involved in any legal cases at this time (traffic, civil, criminal)? YES ☐ NO ☐

Education Information

What is the highest grade level or degree achieved: ________________________________

Do you have any learning disabilities YES ☐ NO ☐
If yes please describe:____

____

____

Employment Information

☐ Full time ☐ Part time ☐ Temp ☐ Laid off ☐ Disability
☐ Retired ☐ Student ☐ Receiving Social Security ☐ Self employed
☐ Looking for work ☐ Unemployed

If you do work …..
Name of Employer: ____

Position:____

How long have you been with them? ________________________________

Military

Military experience? YES NO Combat experience? YES NO

Branch: ___________________________ Discharge Date : ___________________

Date Drafted: _____________________ Type of Discharge: __________________

Date enlisted: _____________________ Rank at Discharge: __________________

Current Medical / Physical Health

Check all that apply and describe below as needed:

	Aids		Diabetic		Mumps		Tuberculosis
	Alcoholism		Diarrhea		Miscarriages		Toothache
	Abortion		Dizziness		Neurological disorders		Thyroid problems
	Allergies		Drug abuse		Nausea		Vomiting
	Anemia		Epilepsy		Nose bleeds		Whooping cough
	Arthritis		Ear infection		STD		Other:
	Asthma		Eating disorder		Sleeping disorder		
	Bronchitis		Fainting		Sore throat		
	Bed wetting		Frequent urination		Scarlet fever		
	Cancer		Hearing problems		Sinusitis		
	Chest pain		Hepatitis		Small pox		
	Chronic fatigue		High blood pressure		Stroke		
	Constipation		Kidney problems		Sexual issues		
	Chicken pox		Measles		Tonsillitis		

Current prescribed medication & dosage

Please check if there has been any recent changes in the following:

	Sleep patterns		Eating patterns		Behavior		Energy level
	Physical activity level		General disposition		Weight		Nervousness or tension

Chemical Use History

	Method of use and amount	Frequency	Age of first usage	Age of last usage	Used in last 48 hours?	Used in last 30 days?
Caffeine					Yes NO	Yes NO
Nicotine					Yes NO	Yes NO
Alcohol					Yes NO	Yes NO
Marijuana					Yes NO	Yes NO
Barbiturates					Yes NO	Yes NO
Valium/ Librium					Yes NO	Yes NO
Cocaine/ crack					Yes NO	Yes NO
Heroin/ opiates					Yes NO	Yes NO
LSD, PCP, etc					Yes NO	Yes NO
Inhalants					Yes NO	Yes NO
Bath salts					Yes NO	Yes NO
Over the counter					Yes NO	Yes NO
Huffing					Yes NO	Yes NO
Other:					Yes NO	Yes NO
					Yes NO	Yes NO

For staff use only

Client account number: ______________________________________

Therapist signature: ____
Date

Comments: