Counseling by Kate, LLC

Kate Knapp Lengyel, J.D., M.S., LPC, Mediator

Licensed Professional Counselor

CLIENT INFORMATION

Name_____ **Date**_____

Address_____ **City** _____ **Zip** _____

Phone #'s: HM _____ **WK**_____ **Mbl** _____ **□ message OK?**

E-Mail Address _____ **□ Check if OK to send email.**

# of Children _____ **Marital Status** _____**Age** _____ **Birthday** ____ /____ /_____

Employment _____ **Social Security Number** _____

Person Responsible for Payment: _____

DL # _____ **Referred by:** _____

Insurance carrier: _____ **ID:**_____

Group #:_____ **Primary Insured** _____ **DOB** _____

***Emergency Notification*:**

Name _____**Relationship** _____ **Phone** _____

I hereby give the office of Counseling by Kate permission to begin services with me for the purpose of counseling, parenting coordination, parent coaching or collaborative law. I also give it permission to exchange any information necessary for services performed and insurance claims billing (if necessary). I also acknowledge **receipt of Notice of Policies and Practices to Protect the Privacy of Your Health Information.**

_____ _____

Signature **Date**

_____ _____

Signature **Date**

Counseling by Kate has permission to leave messages and communicate with me even though it may contain personal health information:

□cell □home □work □email □text

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The information of the following intake form is crucially important in making the correct decisions in the direction of treatment. Please answer the following questions as completely as possible ignoring those that do not pertain to your life situation. What is your chief concern at this time?

What stressful events have recently occurred? _____

_____

_____

Please check any current symptoms you are experiencing.

____ Decreased Energy	**____ Panic Attacks**	**____ Intrusive/Negative Thoughts**
____ Guilt	**____ Excessive Worry**	**____ Concentration Problems**
____ Sleep problems	**____ Anxiousness**	**____ Obsessions/Compulsions**
____ Hopelessness	**____ Worthlessness**	**____ Relational Difficulties**
____ Eating Problems	**____ Impulsivity**	**____ Hyperactivity**
____ Tearfulness	**____ Irritability**	**____ Inappropriate anger**
____ Mania	**____ Delusions/Hallucinations**	
____ Dissociative States	**____ Increased Alcohol Use**	**____ Use of Illegal Substances**
____ Thoughts of Death/Suicide		**____ Self Injurious Behavior**

Other Symptoms

_____

When would you estimate that these symptoms began? _____

What has been the course of your symptoms? (i.e. getting better, worse, or staying the same) _____

Have you experienced similar symptoms before? ___ When? _____

What have you tried that has made the symptoms better/worse? _____

What (if any) medications are you taking or have you tried? _____

Have you consulted other health professionals concerning your symptoms? _____

Do you smoke? Y N Do you consume alcohol? Y N Do you use marijuana? Y N

How many drinks per week? _____ How often use marijuana?_____

Have you ever used an illegal substance or legal substance illegally? _____

If so, please share when and for how long. (Substance use can create or influence depression/anxiety)_____

Do you have a supportive/spiritual community? _____ Explain _____

Briefly describe your relationships in your family of origin: _____

_____

Briefly describe your current significant relationships: _____

_____

Have you ever been the victim of abuse or experienced a traumatic event? Y N

Explain: _____

Have you ever been married before? _____ Explain relationship _____

_____

Please share any other information you want me to know before we begin.

_____

_____

THERAPIST NOTES:

_____
_____
_____
_____
_____
_____
_____
_____

Diagnostic Impressions/TX plan:

_____
_____

_____ **Kate Knapp Lengyel, JD, MS , LPC**