Intake and Initial Assessment
Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC

CLIENT INFORMATION

Legal Name: _____ Date of Birth _____

Preferred Name: _____ Age: _____

SS# _____ Pronouns: _____

Gender Identity: Female Male Gendequeer Trans _____

Racial/Ethnic Identity: Asian Black Latinx White _____

Sexual Orientation: Bisexual Gay Hetero Lesbian Pansexual Queer _____

CONTACT INFORMATION

Address: _____ Apt# _____

City: _____State: _____ Zip Code: _____

Mailing Address or P.O. Box: _____

City: _____State: _____ Zip Code: _____

Phone: (HOME) _____ OK to leave message? YES NO

Phone:(CELL) _____ OK to leave message? YES NO

E-mail: _____ OK to leave message? YES NO

EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone: _____

EDUCATION/EMPLOYMENT

Highest Level of School Completed: 9 10 11 12 GED AA BA/BS MA/MS PhD

Occupation: _____ In School? YES NO _____

Employer: _____ Hours worked per week _____

Salary: _____

Guardian's Name (if under 13): _____

Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC
1421 – 34th Ave. Suite 205
Seattle, WA 98122
206-354-7971
Lavonnebryan@fortitudetherapy.com

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RELATIONAL

Relationship status: Single Married Partnered Separated Divorced Widowed

If married/partnered, how long? _____ If separated/divorced, how long? _____

Do you have any children? YES NO If yes, do you have custody? _____

If yes, please note ages and names _____

Who do you currently reside with? _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Are you currently receiving medical treatment? YES NO

If Yes, please specify: _____

Current Medications and what taking for: _____

_____

Prescriber's Name: _____ Phone: _____

Name of prior Therapist/Clinic (within 3 years): _____

PRESENTING ISSUES

Why are you seeking therapy?

_____

_____

_____

What are your concerns or goals for therapy?

_____

_____

How long have you experienced these concerns?

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Please check any of the following areas related to current or past experience:

____ Addictions	____Aging	____ Auditory or visual hallucinations
____ Anger	____ Anxiety	____Bullying
____ Childhood Abuse	____Chronic Pain	____ Coming out issues
____ Cultural Identity	____ Depression	____ Difficulty focusing
____ Dissociating	____ Domestic Abuse	____ Drug/Alcohol Abuse
____ Eating Disorders	____ Family issues	____Fears/Phobias
____ Financial issues	____Gender care	____ Grief/Loss
____ Health problems	____ Insomnia	____ Legal Matters
____ Nightmares	____ Obsessive thoughts	____ Parenting issues
____ Past/current trauma	____ Postpartum Depression	____ Racial/Ethnic oppression
____ Relationships	____ Religion/Spirituality	____ Self harm
____ Separation/Divorce	____ Sexual Assault	____ Sexual identity
____ Social Anxiety	____Stress	____ Suicidal thoughts
____ Work problems	____ Negative thought patterns	

Other: _____

_____

Have you been previously diagnosed with a mental health/psychiatric condition? YES NO

If Yes, please list: _____

Are you currently having suicidal thoughts? YES NO

Have you experienced suicidal thoughts in the past? YES NO

Have you ever attempted suicide? YES NO

If Yes, when and how: _____

_____

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Have you had any previous psychiatric hospitalizations? YES NO

If Yes, when and where: _____

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family, immediate or extended; been diagnosed or suffer from any mental health issues or substance related disorders? (If yes, please indicate the diagnosis and the family member).

_____

_____

SUPPORT SYSTEM

Do you have personal supports? YES NO

If Yes, who: _____

REFERRAL SOURCE

How were you referred? Online Directory Website Friend/Family Other

Name of person/directory/other: _____

May I have your permission to thank this person for the referral? YES NO

Official Use only

Diagnosis(es):

Diagnostic/Procedural Code:

Date: _____

_____

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