Jennifer Palau, MSW, LICSW
16771 NE 80th St., Suite 204
Redmond WA 98052

CLIENT INTAKE FORM

Name ___________________________________Age _______ Date of Birth____________

Address___________________________________ City ______________________________

Zip ___________ Home or Cell Phone ____

Email ____

Preferred contact method: Email ☐ Phone ☐ Text ☐

Is it okay to leave a phone message? Yes ☐ No ☐

How did you hear about Jennifer Palau, LICSW?__________________________________

Parent's Name Email Cell Phone #

____

____

Name of Employer or School______________________________________Grade________

Gender Identification _______________________ Sexually Active? Yes ☐ No ☐

Sexual Orientation ________________________________Race /Ethnicity_______________

Relationship Status (adult client):

☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Married ☐ Partnered

If under 21:

What is your relationship with your parents?

☐ OK ☐ Good ☐ Challenging ☐ Would like to improve it

What is your parent's relationship status?

☐ Single ☐ Dating ☐ Partnered ☐ Divorced ☐ Married

Who are the people living in your home?

Name(s)	Gender	Age	Describe your relationship

Mental Health Information

Have you ever had counseling before? Yes □ No □

If yes, briefly describe the reason, the therapists name, approximate dates and whether the counseling was helpful.

Briefly describe what brings you to counseling today?

What goals would you like to achieve from counseling?

Medication Information:

Name of Medication	Dosage	Date Started	Prescribing Physician

Substance Use History:

Have you ever experienced any consequences (Family, Physical, Legal, Work, School) due to your use? Yes □ No □ If yes, describe briefly:

Have you ever had drug and/or alcohol counseling or treatment?

Yes □ No □ If yes, when and where?

____

____

Has anyone ever thought you had a problem with substances? Yes □ No □

Who?____

Please check any of the following issues that are a concern for you.

	Insomnia		Cutting / Self Harming		Burning/Picking skin
	School or Work Issues		Drug or Alcohol Abuse		Urge to Harm Others
	Depressed Mood		Chronic Pain		Grief/Loss
	Relationship Issues		Stress		PTSD
	Mood Swings		Anger		Disordered Eating
	Repetitive Thoughts/ Behaviors		Physical Health Problems		Suicidal Thoughts/ Attempts
	Anxiety		Gender Identity		Emotional Abuse
	Panic Attacks		Legal Problems		Sexual Abuse

Have you ever attempted suicide? Yes □ No □ If yes, please describe further:

Date Prompting Event Means of Attempt (How) Hospitalized?

____

____

When was the last time you had thoughts of suicide?

____

____

Did you have a plan? Yes□ No□ If yes, please describe:

____

____

Have you had any self-harming incidents in the last three months? Yes □ No □

When was the most recent incident?

____

Have you ever been hospitalized or gone to the emergency room? Yes □ No □

If yes, please describe:

Date(s) of Hospitalization | What Facility | Reason for Hospitalization

____

____

Please List any mental health diagnosis you have received in the past:

Diagnosis | Date of Diagnosis | Who made this Diagnosis?

____

____

Who, in your immediate family, has experienced the following?

M (Mom) **D** (Dad) **S** (Sibling) **GP** (Grandparent)

	Drug / Alcohol Abuse		Prescription Drug Abuse		Disordered Eating
	Depression / Anxiety		Suicide Attempts		Mental Health Issues
	Mood Swings		Self-Harming Behavior		Anger Problems

Have you ever experienced any traumas or losses in your life? Yes □ No □

If yes, please describe briefly:

____

____

Who do you turn to for support?______________________________________

Emergency Contact Numbers

Name ___________________________Relationship______________Phone______________

Name ___________________________Relationship______________Phone______________