# LATITUDE COUNSELING, PLLC

CLIENT INTAKE FORM

**Please answer all the questions below.** The information that you provide in this form is considered confidential and will be protected.

_____
Social Security Number

_____ ____ _____ _____
Last Name First Name M.I. Age Date of Birth Gender

Parent/Guardian's Name (if minor):

_____ ____ _____ _____
Last Name First Name M.I. Age Date of Birth Gender

_____ _____ _____
Street Address City Zip Code

_____
E-mail address

Send e-mail reminders and announcements from Latitude Counseling, PLLC? ☐Yes ☐No

_____
Home Phone

Ok to leave a message? ☐Yes ☐No

_____
Cell Phone

Ok to leave a message? ☐Yes ☐No

Marital Status: ☐ Single ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name (if applicable) _____

Children's name and age (if applicable)

_____ _____
Name Age

_____ _____ _____ _____
Name Age Name Age

**Whom may we contact in the case of an emergency?**

_____ _____ _____
Name Relationship Phone Number

**EMPLOYMENT/ EDUCATION (if minor):**

_____ _____
Company/School name Address

How did you hear about Latitude Counseling? _____

Referred by (if any): _____

**MENTAL HELATH HISTORY:**

Have you previous received any mental health services (psychotherapy, psychiatric, counseling, etc.?
☐Yes ☐ No

_____

Where? (therapist, practitioner, location) When?

_____

Where? (therapist, practitioner, location) When?

Do you currently use prescription medication? ☐ Yes ☐ No

If yes, please list current and past history of psychiatric medications and medical condition used for:

_____ _____

_____ _____

Have you experienced prolonged or recurring:

| | | | |
|---|---|---|---|
| ☐ Nightmares | ☐ Problems with Sleep | ☐ Appetite Changes | ☐ Lack of energy |
| ☐ Depression | ☐ Anxiety | ☐ Phobias | ☐ Panic Attacks |
| ☐ Nervous Condition | ☐ Hallucinations | ☐ Attention Problems | ☐ Grief/loss |
| ☐ Abuse | ☐ Sexual Disorder | ☐ Alcoholism | ☐ Drug Abuse |

Have you ever had suicidal thoughts or attempted? ☐ Yes ☐ No, If yes, when? _____

**FAMILY HISTORY:**

Is mother living? ☐ Yes ☐ No Is father living? ☐ Yes ☐ No

_____ _____

Name Age Name Age

Do you have brothers or sisters? ☐ Yes ☐ No How many? _____ What number are you? _____

Please indicate below if there is a family history of the following. If yes, indicate which family member.

| | |
|---|---|
| ☐ Alcohol/ Substance Abuse | _____ |
| ☐ Anxiety | _____ |
| ☐ Depression | _____ |
| ☐ Domestic Violence | _____ |
| ☐ Eating Disorder | _____ |
| ☐ Obsessive Compulsive Disorder | _____ |
| ☐ Schizophrenia | _____ |
| ☐ Suicidal Attempts/History | _____ |

Are currently involved in a romantic relationship? ☐ Yes ☐ No If, yes, for how long? _____

On a scale 1-10, how would you rate your relationship? _____

Have you experience any significant changes or stressful events in your life recently? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently employed? ☐ Yes ☐ No Explain: _____

Do you enjoy your current work? ☐ Yes ☐ No

Is there anything stressful about your work _____

Do you consider yourself a spiritual or religious person? ☐ Yes ☐ No

I yes, describe belief: _____

What do you consider your strengths? _____

What do you consider weakness? _____

What would you like to accomplish trough therapy? _____

_____

I understand and agree that I have read all the information on the 3 pages of this form and have completed all answers. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in the above information.

_____ _____

Client's Signature (parent/guardian if minor) Date