Emily Moen, Certified Counselor
206-659-9957
Emily@EmilyMoencounseling.com
snocounseling.com
207 Ave D, Suite 100
Snohomish, WA 98290

Client Intake Form – Adult

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Identified Gender_____ Gender/Preferred Pronouns _____

Address _____

Contact Phone Number(s) Cell_____ Other_____

Contact E-Mail Address _____

Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other

Number of children _____

Names and Ages of children _____

Occupation _____ Employer _____

Ethnicity _____ Religion _____

Emergency Contact Information

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Client Health History

Are you currently working with a physician, psychiatrist, or other healthcare provider?
☐ YES ☐NO
Physician Name & Practice Name_____
Would you like me to coordinate with this provider? ☐ YES ☐ NO

History of Mental Health Services: _____
History of Psychiatric medication ☐ YES ☐ NO
List: _____

Previous Mental Health diagnosis ☐ YES ☐ NO
List: _____

Current Medications ☐ YES ☐ NO
List: _____

Relevant Medical Diagnosis: _____

History of substance use/abuse? ☐ YES ☐ NO Current? ☐ YES ☐ NO
Are others concerned about the amount of alcohol you drink / your recreational drug use?
☐ YES ☐ NO

Generally, how do you sleep? Check all that apply:
☐ Great! ☐OK ☐Hard to fall asleep ☐Hard to wake up ☐Wake up frequently at night

Generally, how often are you active (exercise, play, garden, etc.)? Check all that apply:
☐ Hardly ever ☐1x per week ☐2-3 times per week ☐4x or more per week ☐Daily

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO
If yes, when? _____

Have you ever made a plan to commit suicide or attempted suicide? ☐ YES ☐ NO
If yes, when? _____

Do you currently have thoughts of ending your life, or acting recklessly in a way that would kill you? ☐ YES ☐ NO

Please list any additional information you would like me to know:
_____
_____

Please check following symptoms or issues that apply to you:

☐ Anxiety	☐ Depression	☐ Decision Making
☐ Stress	☐ Sexuality	☐ Financial Stress
☐ Drug/Alcohol Use	☐ Anger	☐ Worry/Fear
☐ Self-esteem	☐ Abuse	☐ Strained Relationship(s)
☐ Sleep Changes	☐ Cutting/Self-Harm	☐ Suicidal Thoughts
☐ Health Concern	☐ Life Transitions	☐ Grief and Loss
☐ Disordered Eating	☐ Trauma	☐ Divorce/Separation
☐ Focus/Attention	☐ Lack of Motivation	

Other: _____

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10

To what degree do your problems affect your ability to perform at work, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10

When did these problems begin, and what was happening in your life at that time?

_____

_____

_____

_____

Client Interest in Counseling Services

Please describe what brings you to counseling:

_____
_____
_____
_____
_____

What are your goals for counseling?

_____
_____
_____
_____

How motivated do you feel to work on your goals? Do you have concerns about counseling or working on these issues?

_____
_____
_____
_____
_____

Please list your current hobbies:

_____
_____

What do you consider to be your strengths?

_____
_____
_____

Form completed by: _____ Date: _____

Signature: _____