LiveWell Counseling, LLC

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CLIENT INTAKE FORM

Name:_____**DOB:**_____

What are your Primary concerns/symptoms at this time:

How long have you been experiencing these symptoms or issues:_____

On a Scale of 1-10 how disturbing is this issue for you today: _____

Are there any obstacles that could prevent you from getting treatment?_____

Co-occurring Symptoms (Please check):

Substance use/abuse	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Behavioral addictions/concerns	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Event related stress	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
History of trauma or abuse	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Suicidal ideation or attempts	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Homicidal ideation or attempts	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Marital/relational issues	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Anxiety or Panic attacks	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
School/learning related issues	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Hallucinations or delusions	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Sleep Issues	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Difficulty at work	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Inability to concentrate	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Social/relationship challenges	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	
Loss of interest/motivation	☐ None.	☐ Mild	☐ Moderate	☐ Severe	☐ Onset	

Medications

If you are currently taking any prescribed or self-administered medications please list each medication, dose, length of time that you've been taking the medication, name of administering physician and reason for taking it:

RX:_____Dose:_____Yrs/Mos_____Reason:_____

RX:_____Dose:_____Yrs/Mos_____Reason:_____

RX:_____Dose:_____Yrs/Mos_____Reason:_____

RX:_____Dose:_____Yrs/Mos_____Reason:_____

RX:_____Dose:_____Yrs/Mos_____Reason:_____

Name of Prescriber:_____

Contact Information:_____

**Will not contact without consent

What are your goals for Therapy:_____

_____

_____

_____

OFFICE USE ONLY

Treatment Plan:

Goal(s):

_____

_____

Methods:

_____

_____

_____

Recommendations/Considerations: _____

_____