Patricia McClure, MA, LMCHA
1730 Minor Ave East, Suite 1140
Seattle, WA 98101
206-226-7943
patti@oneowlcounseling.com

CONFIDENTIAL CLIENT INTAKE

Please fill out this form and bring it to your first session. Please note: All information you provide here will remain confidential.

Name:_____

Mailing Address:_____

Phone Numbers:

Home: _____ May I call you here? Yes No

Work: _____ May I call you here? Yes No

Cell: _____ May I call you here? Yes No

E-mail: _____ May I email you? Yes No

Birth Date: _____ /_____ /_____ Age: _____ Preferred Pronoun: He She They

Relationship Status: Single, Partnered, Living Together, Married, Polyamorous, Separated, Divorced, Widowed

Please list any children/age: _____

Name of Parent or Guardian (if under 18):_____

Emergency Contact Name: _____ Number: _____

Please circle any of the following that you are experiencing:

Anxiety/Panic Attacks	Depression	Fears/Phobias	Grief
Eating Disorders	Sexual Challenges	Suicidal Thoughts	Relationship Challenges
Financial Difficulties	Drug/Alcohol Use	Work Stress	Self-Control Difficulties
Anger	Unhappiness	Insomnia	Spiritual Questions
Life Transition	Health Problems	Parenting Challenges	Cutting/Self-Mutilation

Other:_____

GENERAL HEALTH, MENTAL HEALTH, & HISTORY OF CARE

Name of Personal Physician & Phone Number: _____

How would you describe your current physical health?
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Are you currently taking any prescribed medications? If yes, please identify the medications.

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N If yes, please give the name and date of the therapy and briefly explain the circumstances:

Have you ever been hospitalized? Y / N If yes, please give the date and briefly explain the nature of the problem that required attention:

How often do you drink alcohol? Never Rarely Monthly Weekly Daily

How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily

Have you ever had thoughts of suicide? Frequently Sometimes Rarely Never

Do you have any family history of mental or physical health problems? Please identify family member and diagnosis.

What significant life changes or stressful events have you experienced in the past year?

What are your strengths?

What are your goals for our counseling work?

Is there any additional information you think it would be helpful for me to know as we begin to work together?

Thank you for taking the time to complete this form as thoroughly as possible!