LMVCOUNSELING
Lauren Moser Vilar | MSW, LSCW, LCAS

Today's date: _____

Adult Client Intake Form

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Name:		Date of Birth:	Preferred Name:	
*Preferred Pronouns:	Legal Sex: ❑ Female ❑ Male	Gender:	Race:	Age:
Home Address:		City:	State:	Zip Code:
Home Phone:	Cell Phone:	May we text appointment reminders? ❑ Yes ❑ No	Email:	
Emergency Contact Name:		Phone:	Emergency Contact Relationship:	

* While LMV Counseling, PLLC recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these please let us know.

For appointment reminders or other necessary calls or emails, indicate any restrictions (please include any issues with a controlling spouse or partner):_____
_____

What brings you to counseling? _____
_____
_____

B. Referral: Who gave you my name to call?

Name:	Phone:	May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you?
_____
_____
_____

C. Medical Care: From whom or where do you get your medical care?

Clinic/Doctor's name:	Phone:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that she or he can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Current medications and dosages (including psychiatric medications): _____
_____

Allergies: _____

(Females only)

Have you ever been pregnant? ❑ Yes ❑ No	How many pregnancies?	Have you ever terminated a pregnancy for any reason? ❑ Yes ❑ No If yes, how many?

D. Psychiatric History

Please check symptoms that you are currently experiencing:

❑ Depression
❑ Isolation
❑ Low self-esteem
❑ Hopelessness
❑ Guilt and shame
❑ Fatigue
❑ Suicidal thoughts
❑ Lack of motivation
❑ Easily tearful
❑ High energy
❑ Anger
❑ Impulsivity
❑ Memory difficulties
❑ Anxiety
❑ Panic
❑ Sleep problems
❑ Self-harm (cutting, burning, skin picking, etc)
❑ Difficulty concentrating
❑ Emotional outbursts
❑ Concerns about eating patterns
❑ Flashbacks
❑ Nightmares
❑ Hearing sounds or voices
❑ Repetitive behaviors
❑ Grief
❑ Relationship conflict
❑ Sexual problems
❑ Feeling overwhelmed
❑ Feeling keyed up or tense
❑ LGBTQI difficulties

Psychiatrist's name:	Phone:	Have you ever attempted suicide? ❑ Yes ❑ No If yes, what is the date of your last attempt?
Have you ever been hospitalized for psychiatric care? ❑ Yes ❑ No	List all past or current known psychiatric diagnosis or conditions:	

If you enter treatment with me for psychological problems, may I tell your psychiatric provider so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Substance Use

Do you use alcohol? ❑ Yes ❑ No	If yes, what is the date of your last use?	Amount and frequency?
Do you use any other mind altering substances or drugs (including marijuana)? ❑ Yes ❑ No	If yes, what was the date of the last use?	Amount and frequency?
What type of drug(s) do you use?		
Do you use nicotine? ❑ Yes ❑ No	If yes, what type (dip, cigarettes, e-cigs, cigars, etc)?	Amount and frequency?
Do you drink caffeine? ❑ Yes ❑ No	If yes, how many cups/doses a day?	
Are you currently in recovery? ❑ Yes ❑ No	If yes, how much time do you have in recovery?	
Have you ever overdosed on drugs or alcohol? ❑ Yes ❑ No	If yes, when and from what substance?	
Do you have a history of injecting drugs? ❑ Yes ❑ No	If yes, when was your most recent HIV/Hep C screening?	

F. Employment and Education

Current Employer:	Occupation	How many hours a week do you work?
Average Household Income:	What was the highest grade you completed in school?	Have your difficulties with mental health or substance use interfered with your work? ❑ Yes ❑ No
If answered yes, what type of problems has your mental health or substance use interfered with your work?		

G. Family history

Relative	*Current Age(s)*	*Medical conditions*	*Mental Health or*	*Occupation*

		(or cause of death if deceased)	*Substance Use History (including suicide attempts and completions)*	
Mother				
Father				
Siblings				
Maternal grandparents				
Paternal grandparents				

F. Relationships and Marital Status

Relationship status: ❑ Married ❑ Partnered ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Other:	How would you rate the quality of your romantic relationship? ❑ Excellent ❑ Good ❑ Fair ❑ Poor	Do you have any children? ❑ Yes ❑ No Age(s):

Thank you for taking the time to complete this intake packet. This will help inform my work with you to provide the best care possible.