Rain Marie Voss, LPC-MHSP
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Client Intake Form

Please provide the following confidential information.

Demographic and Contact Information

Name You Go By:_____ Date:_____

Legal Name (if different) :_____ Date of Birth: _____

Contact Phone Number:_____ Email:_____

May I Leave a Voice Message? ☐ Yes ☐ No
Text Message? ☐ Yes ☐ No
Email? ☐ Yes ☐ No

Race/Ethnicity: _____ Country of Origin: _____

Gender:

☐ Woman
☐ Man
☐ Cisgender
☐ Transgender
☐ Nonbinary
☐ Genderqueer
☐ Not listed (please specify):
_____
☐ Prefer not to answer

Pronouns:

☐ she/her/hers
☐ he/him/his
☐ they/them/theirs
☐ Not listed (please specify): _____

Relationship Status:

☐ Single
☐ Married
☐ In relationship(s) but not married
☐ In relationship(s) with multiple partners
☐ Separated
☐ Divorced
☐ Widowed
☐ Not listed (please specify):
_____
☐ Prefer not to answer

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Please list the names of your partner(s) and children if applicable, including ages: _____

_____

_____

Emergency Contact: _____
(Name) (Relationship) (Telephone)

Health and Wellbeing

Primary Care Physician: _____ Last Seen: _____
(date)

Psychiatric Provider: _____Last Seen: _____
(date)

Current Medications (please list name, dosage and frequency): _____

_____

_____

Please describe the following:

Your overall health, including any chronic health conditions: _____

_____

_____

Sleep Quality: _____

Exercise Habits: _____

_____

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Eating Patterns/Diet: _____

_____

Quality of Relationships with Partner(s), Family, Friends and Larger Community: _____

_____

_____

_____

Frequency of Recreational Drug Use: □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Frequency of Alcohol Use: □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Spiritual Beliefs/Religious Affiliation: _____

_____

_____

Current Employer, Type of Work, and Satisfaction with Employment: _____

_____

_____

Referral Source: (how did you find me?) _____
If another mental health professional or current client, are you comfortable with me thanking them for the referral?

☐ Yes, you have my consent to thank them.
☐ No, I prefer to keep it confidential.

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Mental Health

Are you currently experiencing any of the following (check, if yes):

☐ Sadness ☐ Irritability ☐ Crying Spells ☐ Suicidal Thoughts

☐ Lack of Pleasure. ☐ Lack of Energy ☐ Trouble Concentrating ☐ Restlessness

☐ Fear ☐ Worry ☐ Excessive Anger ☐ Excessive Guilt ☐ Troubling Thoughts

☐ Homicidal Thoughts ☐ Overwhelm ☐ Paranoid ☐ Confused ☐ Ashamed

☐ Panic Attacks ☐ Indecisiveness ☐ Insomnia ☐ Impulsivity. ☐ Addictive Behaviors

Have you previously received any type of mental health services (psychotherapy, psychiatric services, inpatient stay, intensives etc.)? □ Yes □ No

If yes, please provide the provider's name, location, dates, and treatment focus.

_____

(Provider/Location) (Dates) Focus)

_____

(Provider/Location) (Dates) Focus)

_____

.(Provider/Location) (Dates) Focus)

What are you hoping to work on in the context of therapy?_____

_____

_____

_____

_____

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Have you experienced trauma of any kind (Including abuse, neglect, sexual assault, violent crime, loss, poverty, racism, among many other things)? If so, please describe: _____

_____

_____

_____

_____

Please tell me about some of your strengths: _____

_____

_____

_____

Is there anything else you would like me to know at the start of our work together?

_____

_____

_____

_____

_____

Thank you for taking the time to share about yourself and your reasons for coming to therapy. I look forward to our work together. And please, don't hesitate to share any questions or concerns that may have arisen in the process of filling out this form.