LeBauer
COUNSELING

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Client Intake Form

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. Please provide as much information as possible. Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Today's Date: ______________________________

Name: ______________________________ Birth Date: ________________ Age: _______

Occupation: ____

Employer: ____

Gender Identification: ______________________ Preferred Pronouns: ______________________________

Relationship Status: ____

Partner's/s' Name(s) (if applicable): ____

Do you have or might you get coverage by **Medicaid**? ☐ Yes ☐ No If **yes**, you can stop here.

How did you hear about LeBauer Counseling?

☐ Word of Mouth ☐ Professional Referral ☐ LeBauerCounseling.com

☐ TherapyHelp.com ☐ Other: ____

Referral Information:

I like to thank referral sources for sending clients my way. Whom may I thank for referring you to me?

Name: ____________________________________ Phone: ______________________________________

Address: ____________________________________ Email: ______________________________________

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

Emergency Contact: In case of an emergency, Matthew LeBauer, LCSW may be required to contact someone on your behalf. Please list your emergency contact below, who Matthew LeBauer, LCSW may contact on your behalf. Matthew LeBauer, LCSW will only share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: ____ Phone: ____________________

Relationship: ______________________________________

Personal History:

Thank you for taking the time to **complete this questionnaire individually**. Your candid input will provide important details that will help our work together. Please complete this form on your own; if you're here for couples counseling, your partner will have the same opportunity.

Do you have any children: ☐ Yes ☐ No

If yes, please indicate their names, ages, and your relationship to them, including biological, step-, foster, adoption, and legal relationships with other parents.

Name: ______________________ Age: _____ Relationship: __________

Name: ______________________ Age: _____ Relationship: __________

Name: ______________________ Age: _____ Relationship: __________

It is the policy of Matthew LeBauer, LCSW not to treat any of your children while providing services to you. It is not within Matthew LeBauer, LCSW's scope of practice to provide recommendations for custody arrangements.

Please describe the main concern(s) that has/have brought you to see me:

____

____

How have you dealt with these issues/concerns in the past:

____

For how long have you been experiencing these concerns? ______________________

Please list other conditions, mental health concerns and medical diagnoses:

____

____

Please describe any recent losses or significant changes in your life:

____

____

Please describe any family history of mental illness and/or substance abuse:

____

____

Please indicate medications you have taken or are taking (if you are not currently taking any medications, please state that you are not currently taking any medications):

Medication	For What?	Results ?	When/How long?	Prescribing Doctor?

How many hours of **sleep** do you get per night? _____

Please describe any **problems sleeping**: ______________________

How would you describe your **diet**? ______________________

Have you noticed any major **weight changes** in the last 6 months? ☐ Yes ☐ No

When was your last annual **physical**? ______________________________

Who is your Primary Care Physician? ______________________________

Are you **currently** receiving counseling, psychotherapy, or psychiatric treatment? ☐ Yes ☐ No

If yes, for what concerns? ______________________________

Who is your provider? ____________________ Tel: ____________________

Have you received counseling, psychotherapy, or psychiatric treatment **in the past**? ☐ Yes ☐ No

If yes, for what concerns? With what results? From whom? ______________________________

Have you ever been hospitalized for a psychiatric concern? ☐ Yes ☐ No

If yes, please explain: ______________________________

Have you **used aggression or violence** to influence others or to get your way? ☐ Yes ☐ No

Have you ever been **incarcerated or imprisoned**? ☐ Yes ☐ No

Are you currently involved in **any civil or criminal legal proceedings?** Please describe below: ☐ Yes ☐ No

Have you been the **victim of violence or abuse** (including physical, sexual, verbal and emotional)? ☐ Yes ☐ No

Have you **witnessed** domestic or street violence? ☐ Yes ☐ No

Do you or others in your home have access to **weapons**? ☐ Yes ☐ No

As a child did you experience the death of a parent, friend, or sibling? ☐ Yes ☐ No

Have you ever felt the need to **cut down on your drinking**? ☐ Yes ☐ No

How much beer, wine, or liquor do you consume each week, on average? ____________________

Have you ever been, or are you currently, suicidal? ______________________________

Have you ever attempted to commit suicide? ______________________________

Has anyone in your family ever attempted or committed suicide:

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any recreational or illegal drugs (if so, please indicate which ones):

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate the mental illness): □ YES □ NO

Is there anything else you would like Matthew LeBauer, LCSW to know?

What would you like to accomplish through therapy and/or what goals would you like to achieve?

1. ____________________________________

2. ____________________________________

3. ____________________________________

About how long do you expect to engage in therapy to fully reach these goals?

- ☐ As long as it takes
- ☐ 6-10 sessions
- ☐ 10-15 sessions
- ☐ I'm not sure what to expect.

How would you describe your motivation to actively engage in the therapeutic work, including the essential work done at home between sessions?

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

Client Signature   Date

Checklist of Concerns:

Client Name: ____

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOW	IN THE PAST	NOTES
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Breathing difficulty			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			
Friendships			

Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Hopelessness			
Housework/chores—quality, schedules, sharing duties			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Loss of Interest			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nausea, vomiting			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Parenting, child management, single parenthood			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			

School problems, Career concerns			
Seizures			
Self-blaming			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other; sexual abuse			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (You or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			
Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction			

Other concerns or issues:

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____

____

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

____ ________________

Client Signature Date