Jason Krause, MA
Registered Mental Health Counselor Intern
IMH 17617

Client Intake Form

[The information you provide on this form is confidential and intended to enhance your therapy]

Demographic information:

client name: ______________________________ dob: _____________ age: _____ gender: _________

parent/legal guardian (if under 18): ____

social security number: ___________________________ relationship status: __________________

address: ____

street city state zip code

phone (primary): ____________________________________ consent to leave voicemail: ☐ Yes ☐ No

phone (secondary): __________________________________ consent to leave voicemail: ☐ Yes ☐ No

email: ____

please note: email correspondence is not considered a confidential medium of communication

Emergency contact: ____

Name relationship phone

How did you hear about me / referred by? ____

Mental Health History Information:

have you ever received any mental health services?

☐ No ☐ Yes, previous therapist/practitioner: _______________________________________

are you currently taking any psychiatric medications? ☐ No ☐ Yes, describe below:

____

____

612 E. Colonial Dr. Suite 390 | Orlando, FL
Email: jason@jskrauseconsulting.com
Phone: (407)-850-8226
www.jskrauseconsulting.com

have you ever been prescribed any psychiatric medication? □ No □ Yes, medication/year:

____

____

have you ever experienced suicidal thoughts?

□ No □ Yes, elaborate: ____

please identify if any immediate family members or relatives have ever experienced difficulties with the following. Circle all that apply and identify your relationship:

DIFFICULTY	RELATIONSHIP	DIFFICULTY	RELATIONSHIP
Anxiety		Personality disorder	
Bipolar disorder		PTSD	
Depression		Schizophrenia	
Domestic violence		Self-injury	
Eating disorder		Substance abuse	
OCD		Suicide attempt	
Panic disorder		Other:	

General Health History:

Are you experiencing any current or chronic health conditions? □ No □ Yes, describe below:

____

____

____

Are you currently taking any medications for these conditions? □ No □ Yes, describe below:

____

____

circle any of the following you have experienced in the past 30 days:

Aggression	Anger	Anxiety	Annoyed
Blackouts	Crying	Depressed mood	Envious
Fatigue	Fearful	Grief	Guilt
Hallucinations	Happy	Helpless	Hope
Hopeless	Impulsivity	Insomnia	Intrusive thoughts
Irritability	Jealousy	Lack of motivation	Loneliness
Memory loss	Mood swings	Nervous tics	Optimistic
Panic attacks	Paranoia	Regret	Sadness
Self-doubt	Self-injury	Sexual dysfunction	Sexual obsession
Sleep disturbance	Social isolation	Substance abuse	Suicidal thoughts
Tension	Unhappy	Worry	Worthlessness

Other: ____

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Legal History:

arrest: __________________ date: ______________ consequence: _________________________________

arrest: __________________ date: ______________ consequence: _________________________________

arrest: __________________ date: ______________ consequence: _________________________________

Substance use history:

please identify any substances you have used:

Substance	Age at First use	Date of last use	Frequency	Amount

Education: ____

Employment: ____

Other Information:

please describe your reason(s) for seeking therapy:

____

____

what are your goals for therapy?

____

____

what do you consider to be your strengths?

____

____

do you consider yourself to be spiritual? □ No □ Yes

do you consider yourself to be religious?

□ No □ Yes, what is your religious view? ____

Do you want to incorporate your religious view into therapy? □ No □ Yes

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Is there anything else that would be helpful for me to know about you?

____

____

____

____

____

______________________________ ______________________________ ________

printed name (client) signature (client) date

______________________________ ______________________________ ________

printed name (parent/guardian) signature (parent/guardian) date