David Sanders Counseling

Therapy for Individuals and Couples

INTAKE FORM: PART I

David Sanders Counseling, LLC
Redmond WA · (971) 220-5797

Date _____ /_____ /_____

Welcome! Please share the information below to aid me in understanding you and your concerns. Complete the form as thoroughly as possible. All information will be held confidentially, as explained in my disclosure statement.

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

For scheduling purposes, may I contact you by…

Email? ☐ Yes ☐ No Phone? ☐ Yes ☐ No

Note: In order to protect your privacy, I typically will not identify myself as calling about counseling.

Date of Birth _____ /_____ /_____ Gender _____

How were you referred to me? _____

Relationship status: ☐ Single ☐ Living Together ☐ Married ☐ Informally separated ☐ Legally separated ☐ Divorced ☐ Other: _____

Partner name (if applicable): _____

Briefly tell me about the concerns that have brought you here:

_____

_____

_____

_____

Please check any current or past issues that still affect you:

- ☐ Eating Disorders
- ☐ Stress / Anxiety
- ☐ Phobias (type: _____)
- ☐ Death of a someone close
  - ☐ Recently (when: _____)
  - ☐ In the past (when: _____)
- ☐ Family Issues *(i.e. divorce, alcoholism, domestic violence)*
- ☐ Relationship Concerns
  - ☐ Friend
  - ☐ Parent
  - ☐ Significant other
  - ☐ Roommate
- ☐ Childhood Abuse (i.e. physical, sexual, emotional)
- ☐ Academic Issues
- ☐ Spiritual Concerns
- ☐ Chronic Pain
- ☐ Chronic Illness
- ☐ Alcohol or Other Drug Use
- ☐ Depression
- ☐ Pornography
- ☐ Sexual Identity Issues
- ☐ Difficulty Focusing
- ☐ Suicidal Thoughts
- ☐ Anger Issues
- ☐ Other: _____

INTAKE FORM: PART II

Current medical problems _____

_____

Current medications *(all, including herbal)* _____

_____

Are you currently being treated by any Personal Physician? ☐ Yes ☐ No

Physician's Name: _____ Phone Number: _____

Reason for Treatment: _____

Have you been on any medications in the past for mental health issues? ☐ Yes ☐ No

If yes, please list: _____

Have you previously seen a therapist? ☐ Yes ☐ No

Who/Where? _____ When? _____

For what types of issues? _____

Are you currently seeing a therapist? ☐ Yes ☐ No

Have you ever been hospitalized for physical or mental health issues? ☐ Yes ☐ No

If yes, briefly describe: _____

_____

Have you had any previous suicide attempts? ☐ Yes ☐ No

If yes, briefly describe: _____

_____

Nearest Relative, other than Spouse/Partner:

Name: _____ Phone: _____

Relationship: _____

If you currently experience any of the following symptoms, please rate them from 0-3:

Never = 0 Seldom =1 Often = 2 Always = 3

____ Difficulty concentrating
____ Missing classes
____ Feeling uptight
____ Feeling hopeless
____ Lying to others
____ Feelings of self-doubt
____ Nervous around others
____ Memory loss or blackout
____ Stealing
____ Eating binges
____ Drinking heavily
____ Other drug use
____ Feeling afraid
____ Feeling helpless

____ Crying
____ Worrying
____ Feeling out of control
____ Injuring self
____ Suicidal thoughts
____ Difficulty sleeping
____ Anger
____ Withdrawing socially
____ Feelings of guilt
____ Sexual preoccupation
____ Physical symptoms *(i.e. headaches, digestive)*
List: _____
Other: _____

Have you seen a health care provider for any of these? **Yes No**

Please use the scale below to answer the following questions:

1=Not at all true 2=Somewhat true 3=Mostly true 4=True to a great extent

- _____ My current concerns affect my success in life.
- _____ My current concerns affect my ability to interact and connect with others.
- _____ I am optimistic that I will be able to make some positive changes as a result of counseling.

EMERGENCY NOTIFICATION

Primary Contact:

Name _____

Phone _____

Email _____

Relation to Client _____

Secondary Contact:

Name _____

Phone _____

Email _____

Relation to Client _____

Return this completed form to:

David Sanders Counseling · 15446 Bel-Red Road NE, Suite 430 · Redmond, WA 98052