Cassie Salewske, MA LMHC NCC ACHt
Healing Tree Counseling and Wellness, LLC
1812 East Madison Street, Suite 102, Seattle WA 98122
www.healingtreeseattle.com
206-595-8621

NEW CLIENT INTAKE FORM

GENERAL INFORMATION

Full Name: ____

Name you prefer: __________________________ Pronoun Preference: __________________

Age: _______ Date of Birth: __________________

Racial/Ethnic Identity: White Black Latino Asian Other: _______________________

Gender Identity: Male Female Genderqueer Trans Other: ______________________

Sexual Orientation: Gay Lesbian Bisexual Hetero Queer Other: ________________

CONTACT INFORMATION

Street Address: ____ Suite or Apt. #: _________

City: _________________ State: _____ Zip Code: _______ May I send mail here? Yes No

Mailing Address (if different): ____

City: _________________ State: _____ Zip Code: _______ May I send mail here? Yes No

Email Address: _____________________________ May I send a message here? Yes No

Cell Phone: (____)_________________________ May I leave a message here? Yes No

Work Phone: (____)_________________________ May I leave a message here? Yes No

EDUCATION/EMPLOYMENT INFORMATION

Highest Level of School Completed: 9 10 11 12 GED AA BA/BS MA/MS PhD

Employer: ___________________________________ Length of Employment: ___________

Occupation: _____________________________ Average hours worked per week: ________

RELATIONAL INFORMATION

Current Marital Status: Single Partnered Married Separated Divorced Widowed

Are you content with your current status? Yes No. If No, briefly explain: _____________

____

If Partnered/Married, how long: ________ If Separated or Divorced, how long: __________

With whom do you currently live? *(Check all that apply)*

Alone Spouse/Partner Children (#___) Parent(s) Sibling(s) Boyfriend/girlfriend

Other: ____

PRESENTING ISSUES

Please tell me why you are seeking counseling: ____

____

____

____

How long have these concerns been causing you distress? _____________________________

Please check the boxes below if you've had problems or concerns with any of the following:

Aggressiveness	Past	Present	Loneliness	Past	Present
Alcohol Abuse	Past	Present	Loss of Control	Past	Present
Anger	Past	Present	Making Decisions	Past	Present
Anxiety	Past	Present	Memory	Past	Present
Apathy	Past	Present	Nervousness	Past	Present
Bad Dreams	Past	Present	Pain	Past	Present
Change in Appetite	Past	Present	Panic	Past	Present
Compulsivity	Past	Present	Physical Abuse	Past	Present
Depression	Past	Present	Racing Thoughts	Past	Present
Difficulty Breathing	Past	Present	Rapid Heart Rate	Past	Present
Digestive Upset	Past	Present	Seeing Things	Past	Present
Dizziness	Past	Present	Serious Illness	Past	Present
Drug Abuse	Past	Present	Sexual Abuse	Past	Present
Eating Problems	Past	Present	Sexual Problems	Past	Present
Emotional Abuse	Past	Present	Sleep Trouble	Past	Present
Fatigue	Past	Present	Social Anxiety	Past	Present
Fears	Past	Present	Stress	Past	Present
Finances	Past	Present	Trauma	Past	Present
Grief/Loss	Past	Present	Trouble Focusing	Past	Present
Guilt	Past	Present	Trouble Relaxing	Past	Present
Headaches	Past	Present	Unhappiness	Past	Present
Hearing Noises/Voices	Past	Present	Unwanted Thoughts	Past	Present
Hopelessness	Past	Present	Verbal Abuse	Past	Present
Impulsive Behavior	Past	Present	Weakness	Past	Present
Legal Matters	Past	Present	Work Problems	Past	Present

Have you been previously diagnosed with a mental health/psychiatric condition? Yes No

If Yes, please list: ____

Are you currently having suicidal thoughts? Yes No

Have you experienced suicidal thoughts in the past? Yes No

Have you ever attempted suicide? Yes No

If Yes, when and how: ____

Have you had any previous psychiatric hospitalizations? Yes No

If Yes, when and where: ____

MEDICAL INFORMATION

Do you have health insurance? Yes No

If yes, insurance provider: Regence First Choice Health Other: ___________________

Are you planning to use your insurance for mental health counseling? Yes No

Primary Care Physician: _________________________________ Phone: (____)____________

Address: _______________________________ City: ________________ Zip: ______________

Are you currently receiving medical treatment? Yes No

If Yes, please specify: ____

List any previous conditions, illnesses, surgeries, hospitalizations, or injuries you've had:

____

Current Medications: Dosage: Taking for:

____

____

____

____

SOCIAL SUPPORTS

Do you have a personal support system? Yes No

If Yes, who: ____

Do you regularly attend a place of worship? Yes No

If Yes, where: ____

How important are spiritual matters to you? Not at all Somewhat Very much

Would you like your spiritual/religious beliefs to be included in your counseling? Yes No

REFERRAL SOURCE

How were you referred to me? Online Directory Website Friend/Family Other

Name of person/directory/other: ____

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

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signature: ____ Date: __________________