DragonFly Counseling, LLC
5201 Johnson Drive, Ste: 305
Mission, Kansas 66205

CLIENT INTAKE FORM

Date: _____

Name: _____ **Date of Birth:** _____ **Gender:**____

Race/Ethnicity: _____ **Marital Status:** __Single __Married __Divorced __Separated

Name of spouse/partner (if applicable): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____

EMPLOYMENT

Employer: _____

Address: _____ **Telephone:** _____

Job Title: _____ **Full/Part-time:** _____

Length of time at current position: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Phone:** _____

Relationship: _____

Briefly describe why you are seeking therapeutic services:

_____

_____

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FAMILY HISTORY

Have you experienced the death of significant family members? ___ yes ___no

If yes, whom? _____ Year of Death: _____

FAMILY MEDICAL HISTORY

Circle All That Apply

Diabetes	Substance Abuse	Suicide	Bi-polar Disorder	Psychiatric Hospitalizations	Schizophrenia
Depression	Heart Problems	Anxiety	Cancer	Other medical issues:	_____

EDUCATIONAL HISTORY

Did you graduate from high school? ____ yes ____ no If yes, when? _____

Did you graduate from college? ____ yes ____ no If yes, when? _____

Are you currently attending school? ____ yes ____ no If yes, where? _____

LEGAL HISTORY

Do you have history of contact and/or involvement with law enforcement or the court system? ___

If yes, please explain:

_____

Do you currently have pending charges and/or upcoming scheduled court dates?

____ yes ____ no

Have you ever been on probation or parole supervision? ____ yes ____ no

Name of supervising probation/parole officer: _____

Phone: _____ **Email:** _____

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MEDICAL HISTORY

Primary Care Physician: _____

Address: _____ **Phone:** _____

Please circle any of the following chronic disease or disorders you have been diagnosed with:

Head Injury	Hypoglycemia	High Blood Pressure	Migraines	Diabetes
Heart Problems	Thyroid issues	Liver disorders	Seizures	Ulcers
Sleep disorder	Cancer	Weight loss/Gain	Hepatitis	Headaches

Other (please explain):

_____

Current medications (prescribed and over the counter):

_____

_____

SUBSTANCE USE HISTORY

Do you smoke? __ yes __ no If so, how much & for how long? _____

Do you currently use alcohol? __yes __ no If so, what is the frequency & amount? _____

Do you have a history of substance abuse? ___ yes ___ no

Have you ever participated in a substance abuse treatment program? __ yes __ no

If so, what was the name of the treatment facility, dates attended & did you successfully complete treatment?

_____

_____

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PRIOR MENTAL HEALTH TREATMENT HISTORY

Please complete the following if you have a history of therapeutic services:

Where	When	Diagnosis	Current Status

Have you been hospitalized for psychiatric issues? ____ yes ____ no

If yes, name of psychiatric facility: _____ Date of Discharge: _____

Have you ever been physically, emotionally, or sexually abused? _____ yes _____ no

Have you ever had suicidal thoughts? _____ yes _____ no

Have you ever intentionally hurt yourself? _____ yes _____ no

Have you ever intentionally hurt someone else? _____ yes _____ no

Do you feel hopeful about the future? _____ yes _____ no

By signing below, I acknowledge that the Client Rights/Responsibilities and Notice of Privacy Practices notice for Deanna L. Gonzales, LSCSW, DragonFly Counseling LLC. is posted in the office & on the DragonFly Counseling LLC website.

I may receive/waive receipt of a copy of this document at the time of first appointment.

_____

Client or Responsible Party Signature *Date* *Relationship*