

**SOUND INSIGHT
COUNSELING**

***Cindi S. Whalen, M.S., LMFT
600 Main Street, Suite D
Edmonds, WA 98020
425.422.7843***

**CLIENT INTAKE FORM
and CONSENT FOR TREATMENT**

*(Please bring this completed form to your first session
or mail it to my office at the address above)*

Section I: Client Information

Your Name: _____

Your Phone Number:

(cell) _____

(home/work) _____

May I leave a voicemail message on this phone? Y / N

Your Mailing Address: _____

Your Email Address: _____

Would you like to receive an email notice 24 hours before your appointment? Y/N

Age: _____ DOB: _____ Gender: _____

Your preferred method of payment: Cash Check Credit Card

If Credit Card, are you willing for me to process session fees using Square? Y/N

Would you like me to keep your card number and information on file? Y/N

Your ethnicity/cultural ties: _____

Is your spiritual affiliation important to you? Y/N

If so, what is your spiritual affiliation? _____

Occupation/Profession: _____

Relationship Status: (please circle one)

Single/Dating/Engaged/Married/Separated/Divorced

Children: Y/N

What are their ages and do they reside with you?

What led you to contact me rather than another therapist? _____

Section II: Medical Information

Please tell me about the following:

Current health issues:

Medications (including dosage and purpose):

Primary Care Provider: _____

Phone number: _____

Family history of mental health issues or substance abuse?

Personal history of abuse or trauma? Y/N If so, could you briefly explain the type of trauma or abuse and at what age it occurred? _____

Section III: Presenting Issue(s)

What are the issue(s) or symptoms bringing you to counseling?

When do you believe the issue(s) began? _____

On a scale of 1-10 (10 being the worst), how do these issues/symptoms impact daily life?

Section IV: Your goals for counseling

What goals do you hope to achieve through counseling?

What are some of the ways you and I would know you have achieved those goals?

Section IV: Your previous counseling experience

Have you ever been to counseling before? Y/N

When and with whom? _____

If you are comfortable doing so, please briefly describe the topics you covered in your previous counseling (even if they are the same issues you are currently wanting to address):

How helpful was your previous counseling experience and why?

Are there any events in your family history or facts about your family that you believe would be helpful for me to know regarding the issues you would like to address?

Section V: Assessment of Risk

Have you experienced any of the following (please circle)?

Psychiatric hospitalization	Y/N	Mental health diagnosis	Y/N
Cutting or disordered eating	Y/N	Recent loss	Y/N
Suicide attempts	Y/N	Family history of suicide	Y/N
Domestic violence	Y/N	Childhood traumatic events	Y/N
Recent traumatic events	Y/N	Feelings of hopelessness	Y/N
Obsessive/compulsive behavior	Y/N	Sleep issues	Y/N
Chemical or alcohol dependence/overuse	Y/N		

If yes, which chemical and how often do you use per week now? _____

How many drinks do you have per week? ____ Avg. number of drinks per sitting _____

Other types of addictive behavior? _____

Please describe any past circumstances that placed you at risk for hurting yourself or others:

Would you say that you are currently at risk of harming either yourself or another person? Y/N

If so, please describe the ways you may be able to reduce this risk:

Section VI: Consent for Treatment

I, _____ do hereby give my consent to undergo treatment for the issues listed on this form with Cindi S. Whalen, MS, LMFT. I understand that Cindi Whalen will work with me on my listed goals, but that ultimately reaching these goals is my sole responsibility. I understand that different issues may come up in the midst of attaining my goals and that these goals may be reassessed or changed during the counseling process. I have read, understood, and signed the Disclosure Statement that provides information regarding laws relevant to the counseling process, my financial responsibilities and my rights as a client.

Client(s) signature

Date

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Date

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