Beth Keyserling, LMFT, LPC
Transitions Counseling, LLC

Intake Information

Your Full Name:

_____DOB:_____Age:_____

Home Address:

_____

_____

Mailing Address: (If different)

_____

Phone Number:(h)_____ (w) _____ (c)_____

Email Address:_____

May I call these numbers? _____yes _____no

May I leave a message if you are not available? _____yes _____no

At what number may I reach you in an emergency/last minute appointment change?

_____

Occupation: _____

Employed

By:_____

Marital Status: _____Single _____Married ____ Divorced _____ Separated _____ Other:

_____

Spouse/Partner's Full Name: _____ DOB:

_____

Occupation: _____

Employed By: _____

Phone Number:_____ Email

Address:_____

Children's Names, Ages, & where living at this time:

_____

_____

_____

Please list anyone else living in your household at this time and give their names, ages and relationship to you:_____

Are you currently in therapy with a therapist? _____yes _____no
If yes, please write their name, how long you have been seeing them, and for what reason you have been in treatment with them:

_____

_____

_____

Have you terminated therapy with your therapist? _____yes _____ no
If yes, did you have a termination session with them? _____yes _____ no
Have you had any other previous counseling/therapy? If so, when, with whom and reason for treatment:_____

_____

Please give (approximate) dates of treatment and diagnosis:_____

_____

Was/Were these experiences positive?

_____

If no, please give brief explanation:_____

_____

_____

Have you ever been hospitalized for a psychiatric reason? Please give dates, hospital, doctor & diagnosis: _____

_____

_____

Have you ever attempted suicide? If so, please give dates and more information:_____

_____

_____

Are you currently having suicidal thoughts? _____yes _____ no

If yes, please be specific:

_____

_____

Has anyone in your immediate or extended family committed suicide?

_____

_____

Medical Doctor: _____

Do I have permission to contact your doctor regarding referral of treatment if necessary? _____ yes _____ no

Are you currently taking medication? If yes, what for, what medicine and dosage_____

_____

In case of emergency, who may I contact on your behalf?

_____

His/Her relationship to you?_____

Name:_____

Address:

_____

Phone(s):

_____

How were you referred to treatment today? _____

May I thank them for the referral? _____ yes _____ no