Client Contact Information

Paul Duke, MA, LMHC
Whole Person Counseling
902 Market Street
Tacoma, WA 98402
6626 Wagner St. NW
Gig Harbor, WA 98335
WholePersonGHTacoma@gmail.com
(206) 317-1898

Birth Date: ____/____/________ Age: _____

Gender:
- ☐ Male
- ☐ Female

Name: ____

Address (Street and Number): ____

City ______________________________ State: ________ Zip: _______________

Home Phone: (_____) _____-_________

May We Leave a Voice Message
- ☐ Yes
- ☐ No

Cell Phone: (_____) _____-_________

May We Leave a Voice Message
- ☐ Yes
- ☐ No

May We send Text Messages
- ☐ Yes
- ☐ No

E-mail: ____

May We Email You?
- ☐ Yes
- ☐ No

*Please note: Since email correspondence is not considered to be a confidential medium of communication, only logistics and scheduling will be communicated through email. Anything confidential should be a voice conversation via phone or in person.

Occupation:

Place of Employment:_______________________________

Work Number: (___) _____ -_______

If needed, is it OK to call here?
- ☐ Yes
- ☐ No

Emergency Contact:

Name:____ Relationship: ____

Cell Number: (__) _____ -_______

WHOLE PERSON COUNSELING

Client Intake Form

Paul Duke, MA, LMHC
Whole Person Counseling

902 Market Street
Tacoma, WA 98402

6626 Wagner St. NW
Gig Harbor, WA 98335

WholePersonGHTacoma@gmail.com
(206) 317 1898

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ **Medical Provider:**
- ☐ **Insurance Provider:**
- ☐ **My Website:**
- ☐ **PsychologyToday**
- ☐ **Friend/Family:**
- ☐ **Other:**

Have you previously received any type of mental health services?

- ☐ **Yes**
- ☐ **No**

If yes, which of the following:

- ☐ **Psychotherapy**
- ☐ **Medication**
- ☐ **Outpatient Hospitalizations**
- ☐ **Inpatient Hospitalization**

If yes, please provide:

Name of provider or facility:

Location:

Dates of treatment:

Reason for treatment:

Briefly, what brings you in today:

Are you experiencing behaviors which involve addictive, compulsive or impulsive choices (alcohol, drugs, sex, food, internet, work, etc..) If so briefly describe:

When did your problem first start? Within the last:

- ☐ **30 days**
- ☐ **6-12 months**
- ☐ **2 years**
- ☐ **During adolescence**
- ☐ **During childhood**

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- □ **Yes**
- □ **No**

If yes, for approximately how long? ______________________________

Are you currently experiencing anxiety, panic attacks or have any phobias?

- □ **Yes**
- □ **No**

If yes, for approximately how long? ____

Please put a check next to any that apply in table below

HARM TO SELF OR OTHERS							
Suicidality		**Homicidality**		**Danger to Self**		**Danger to Others**	
	None		None		None		None
	Passive Ideation		Passive Ideation		Ideation		Ideation
	Active/Intent		Active/Intent		Intent		Intent
	Plan		Plan		Plan		Plan
	Means		Means		Means		Means
	Previous Attempts		Previous Attempts		Previous Attempts		Previous Attempts
	Previous Any of Above?		Previous Any of Above?		Previous Any of Above?		Previous Any of Above?

If any of the above is checked, please describe:

Please describe any major losses or traumas you have experienced including abuse, violence of any kind:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

Relationship Status:

- □ **Never Married**
- □ **Romantic Partner – for how long? _________Please provide your partners name _______________________________**
- □ **Domestic Partner – for how long? _________Please provide your partners name _______________________________**
- □ **Married – for how long? _________Please provide your partners name _______________________________**
- □ **Separated – for how long? _________Please provide your partners name _______________________________**
- □ **Divorced – for how long? _________Please provide your partners name _______________________________**
- □ **Widowed – for how long? _________Please provide your partners name _______________________________**

On a scale of 1-10 (best), how would you rate your current relationship?________ your past relationships on average?_______

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Family History

Where were you born? _____________________________ Where did you grow up?____________________________

Please list your parents and siblings. Please use additional space on the back if needed

Name	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? ____

Mother's occupation: ____

Father's occupation? ____

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Condition	Please circle	List Family Member	Briefly Describe Impact on You
Alcohol/Substance Abuse or Addiction	**yes/no**		
Anxiety	**yes/no**		
Depression	**yes/no**		
Domestic Violence	**yes/no**		
Sexual Abuse	**yes/no**		
Eating Disorders	**yes/no**		
Obesity	**yes/no**		
Obsessive Compulsive Disorder	**yes/no**		
Schizophrenia	**yes/no**		
Suicide Attempts	**yes/no**		
Other diagnosed mental health condition?	**yes/no : which was—**		

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Name-Began/Stopped

Prescribing provider and contact information:

Name ____**Specialty:**______________________________**Facility:**________________________

Phone,_____________________________________**Fax**_________________________________**Email**__________________________________

How would you rate your current physical health?

- □ **Poor**
- □ **Unsatisfactory**
- □ **Satisfactory**
- □ **Good**
- □ **Very Good**

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- □ **Poor**
- □ **Unsatisfactory**
- □ **Satisfactory**
- □ **Good**
- □ **Very Good**

If you are having problems, in which phase of sleep are you experiencing issues?

- □ **Falling asleep**
- □ **Staying asleep**
- □ **Awakening early**
- □ **Sleep apnea**

Please list any other specific sleep problems you are currently periencing:

What types of exercise do you participate in:_____________________How many times per week do you generally exercise?______

Are you currently experiencing any chronic pain?

- □ **No**
- □ **Yes**

If yes, please describe:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?