Stepping Stone Counseling LLC
Sarah Strohmayer, MA, LPC, NCC
Licensed Professional Counselor
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Intake Form

Client Name: _____

Date of Birth: _____

Street Address: _____

City, State, ZIP: _____

Best Phone #: _____ Is it ok to leave a message here? Y N

Other Phone #: _____ Is it ok to leave a message here? Y N

If any questions do not apply please leave them blank

Please circle the response which best describes the level of concern in each area:

Family or partner relationships	None	Minimal	Mild	Moderate	Severe	Extreme
School or work relationships	None	Minimal	Mild	Moderate	Severe	Extreme
Emotional Concerns: depression, anxiety, stress, etc.	None	Minimal	Mild	Moderate	Severe	Extreme
Physical Health and Wellness	None	Minimal	Mild	Moderate	Severe	Extreme
Past abuse or trauma	None	Minimal	Mild	Moderate	Severe	Extreme
Alcohol or drug use for self	None	Minimal	Mild	Moderate	Severe	Extreme
Concern for other's alcohol or drug use	None	Minimal	Mild	Moderate	Severe	Extreme
Other Concerns:	None	Minimal	Mild	Moderate	Severe	Extreme

Have you had any major health issues that significantly affected your life?	**Past**	**Current**	**Comments:**
Heart, high blood pressure			
Stomach, digestive problems			
Headaches/migraines			
Pain – muscle, arthritis, other			
Asthma, COPD or other lung conditions			
Seizures			
Dizziness			
Head injury			
Vision problems			
Hearing or speech problems			
Chronic disease (please specify)			
Other issues not yet mentioned:			

Have you ever attempted or had thoughts of suicide? If yes, please explain:

Client Information Form for: _____

Have you ever engaged in self-injurious behavior (e.g. cutting, burning, or hitting self)? If yes, please explain.

Any mental health issues, symptoms or concerns?	**Past**	**Current**	**Comments:**
Depression or grief			
Anxiety			
Mood concerns, bipolar disorder			
Attention problems			
Cognitive, learning or reading problems			
Eating problem – restricting, purging, or overeating			
Significant fear, paranoia, phobias			
Angry outbursts			
Impulsive or reckless actions			
Strange or intrusive thoughts			
Professionally diagnosed chronic mental health condition			
Other issues not yet mentioned:			

How long ago was your last medical exam?: | |

Current Medication(s) and the condition(s) for which they are prescribed:

Do you take your medications as prescribed? Yes or No

Are your medications effective? Yes or No

Do you have any medication allergies, or have you ever had any adverse reactions to medications? If yes, please explain:

Have you ever felt the need to cut down on your drinking or drug use? Yes or No

Have you ever felt annoyed by criticism on your drinking or drug use? Yes or No

Have you ever felt guilty about your drinking or drug use? Yes or No

Client Information Form for: _____

Have you had treatment for substance abuse, addition including gambling? If yes, please explain:

Are you currently involved in, considering or anticipating involvement in any legal proceedings or lawsuits? If yes, please explain:

Do you have any spiritual beliefs that are important for your counselor to be aware of? If yes, please explain:

Are there cultural elements to your family or background that are important for your counselor to be aware of? If yes, please explain:

What is the highest grade-level or educational degree you have completed:

What do you consider to be your occupation?

Have you had any difficulties with unemployment or professional satisfaction? If yes, please explain:

If you are a veteran, do you have concerns that are related to your military experience?

Who currently lives in your household?

Client Information Form for: _____

Do you have any family history of mental health or substance use/abuse concerns? If yes, please specify:

Have you experienced any significant events such as abuse, neglect, a family-member's illness or death, parental conflict, separation or divorce? If yes, please explain:

Who would you list among your closest relationships (e.g. family member, friend, coworker, etc.):

Are there ways you get support in your community (e.g. church, activities groups, etc.)? If yes, please specify:

What are your goals or desired outcomes for counseling?

In case of an emergency, is there a specific hospital you would prefer to be sent or doctor you would like me to call?:

Your email address: _____

Emergency Contact Name and his/her relation: _____

Phone Number: _____

***This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.*