The following pages contain confidential information.

Adult clients: please only fill out the Adult Intake forms.

For clients under the age of 18: Please have parent/legal guardian fill out only the Child/Teen intake forms.

Thank you!

Santel & Kerr, LLC 1385 King Ave Columbus, OH 43212 p: 614-972-7928 www.santelandkerr.com f: 614-473-7142

Kristen Santel, LISW-S Cheri Kerr, LPCC-S Amy Bock, LPCC Mary Beth Gannon, LPCC-S Jackie Savel, MSW, LSW Danielle Weatherholtz, LPCC Michelle Jordan-Frias, LISW

Client Intake Form: Adult

Date: ________________________

Please print the following information.

Client Name:___________________________________ Client Age:_________ Client Birthdate:______________________

Client SSN:____________________________________

Address:_______________________________________ City: _____________________________State_______

_______________________________________ Zip: ________Email: ____________________________

Cell: ______________________________________ May we leave a message via phones?: Yes ☐ No ☐

Home: ______________________________________ May we contact you via email?: Yes ☐ No ☐

Gender/Gender Identity: ________________________ ____

Emergency Contact Information:

Name:____ Relationship: _________________________________

Phone: ______________________________________

Therapy/Counseling History:

Are you currently in therapy or counseling? Yes ☐ No ☐

Counselor Name: _____________________________ Agency Name: _________________________________

Reason: ____

____

____

Phone: ______________________________________ Permission to Contact: Yes ☐ No ☐

Have you ever been in counseling before? Yes ☐ No ☐

When:____ Agency Name: _________________________________

Reason: ____

____

____

Employment

Place of employment: ____

Phone number: ____

Medical History

Physician Name: ________________________________ Phone Number: ________________________________

List any health issues or medical diagnoses, or disabling conditions:

____

____

____

____

Medication Name	Dosage (mg/daily)	Dates Taken	Purpose

Military Service

Are you currently serving or have you served in the military? ____Y ____N If so, please describe:

____

What brings you to counseling or psychotherapy?

____

____

____

Please do your best to express to me <u>*what it feels like to be you*</u> on any given day...

____

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____

____

____

What changes do you want to see as a result of treatment?:

____

____

____

____

____

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Client's Relationship Status:

Please describe any past or current relationship status:

____
____

Concurrent Stressors and Symptoms:

____Depressed Mood ____Worry/rumination ____Feelings of shame ____Feelings of Guilt ____Fatigue/Low Energy ____Poor Concentration ____Irritability/Anger ____Substance Abuse ____Anxiety ____Hopelessness ____Emptiness ____Social Isolation ____Worthlessness ____Loss of pleasure in hobbies ____Appetite gain/loss ____Weight Loss ____Weight Gain ____Intense Crying ____Recurring thoughts/ images ____Feelings of Panic ____Difficulty controlling emotions ____Loneliness ____Memory Problems ____Disorganized Thoughts ____Thoughts of Suicide	____Disordered Eating ____Chronic Pain or disease ____Financial Problems ____Sexual trauma ____Employment Stress ____Lack of Emotional Support ____Infidelity ____Childhood trauma ____Hypersensitivity ____"zoning out" ____Physical Abuse ____Sexual abuse ____Emotional/Mental Abuse ____Seeing or hearing unusual things ____Sexual dysfunction ____Fainting ____Compulsions ____Developmental Disabilities ____Temper Outbursts/rage ____Body Pains or problems ____Fears/Phobias ____Suicide attempts/dates:	____Divorce or Separation ____Problems with attachment ____Adoption ____Recent death ____Communication problems ____Losing time/blackouts ____Sleep too much ____Sleep too little ____Recent traumatic event ____Fertility struggles ____Helplessness ____Feeling disconnected ____Life transition ____Seizures ____Emotional numbness ____Death/Loss ____Loud, Negative Thoughts ____Nightmares ____Uncontrolled emotions ____Grief ____LGBTQ+ Exploration ____Gender Identity ____Trans: ______________ ____Problems with relationships (add):	____Other (add):

Has anyone ever told you that they were worried you had a problem with alcohol and/or drugs? Please explain: _______________
____

Family History of Mental Illness and/or traumatic events (known or suspected):

____
____
____

Client Signature: (by signing below I am stating that all above info I know to be true at this time):

____ ______________________

Client Signature **Date**

CLIENT INTAKE FORM: CHILD/TEEN

Date: ______________________

Please print the following information.

Name of Child :______________________________ Age:_________ Birthdate:____________________

SSN of child: ______________________________ Gender/Gender Identity: ____________________

Address:__________________________________ City: ____________________________________

__________________________________ Zip: __________ Email: ______________________

Adult cell: _____________________________ May we leave a message via phone?: Yes ☐ No ☐

Adult home: _____________________________ May we email parent/guardian ?: Yes ☐ No ☐

Are you the Parent and/or Legal Guardian of child? Yes ☐ No ☐

Emergency Contact Information:

Name:__________________________________ Relationship: ______________________________

Phone: _________________________________ SSN of parent: _____________________________

Is child currently in therapy or counseling? Yes ☐ No ☐

Counselor Name: ___________________________ Agency Name: ______________________________

Reason: ____

____

____

Phone: _________________________________ Permission to Contact: Yes ☐ No ☐

Therapy/Counseling History:

Has child ever been in counseling before? Yes ☐ No ☐

When:__________________________________ Agency Name: ______________________________

Reason: ____

____

____

Please state in your own words why the child is being brought for treatment:

____

____

____

____

Medical History

Physician Name: ______________________________ Phone Number: ______________________________

List any health issues: ____

____

____

____

____

Medication Name	Dosage (mg/daily)	Dates Taken	Purpose

Please list any developmental difficulties:

____

____

____

____

What changes do you wish to see as a result of the child's treatment?:

____

____

____

____

____

____

Known or suspected **trauma, abuse** (physical, sexual, emotional, verbal, mental), **neglect or abandonment** of the child:

____

____

____

____

Is the child currently safe?____

Child Problem Areas/Areas of Concern

	Symptoms	
☐	Sadness:	
☐	Anger/irritability:	
☐	Guilt:	
☐	Fear:	
☐	Shame:	
☐	Panic/anxiety:	
☐	Loneliness:	
☐	Hopelessness:	
☐	Helplessness:	
☐	Emptiness:	
☐	Numbness/lack of feelings:	
☐	Worthlessness:	
☐	Depression:	
☐	Regression:	
☐	Withdrawn:	
☐	Clinging Behavior:	
☐	Language issues:	
☐	Gender Identity/Exploration:	
☐	Disruptive at home or school:	
☐	Substance use:	
☐	Absence from school:	
☐	Fears/phobias:	
☐	Hyperactivity :	
☐	Sleep changes:	

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☐	Suicide attempts:	
☐	Temper/outbursts:	
☐	Self harming behavior:	
☐	Suicidal thoughts/ideas/words:	
☐	Separation anxiety:	
☐	Confusion/memory issues:	
☐	Zoning-out/blackouts:	
☐	Hearing voices or ”seeing things”:	
☐	Body image struggles:	
☐	Lack of concentration/focus:	
☐	Adoption:	
☐	Significant Personality changes:	
☐	Medical trauma:	
☐	Recent traumatic event:	
☐	Changes in relationships with family/friends/school:	
☐	“Scary” or negative thoughts, images, etc.	
☐	Recent death/loss or unresolved grief:	
☐	Social isolation:	
☐	Difficulty with attachment:	
☐	Wetting/soiling:	
☐	Eating Problems :	
☐	Sleeping Problems :	
☐	Hygiene issues:	
☐	Somatic/Body Complaints (sick):	
☐	Seizures:	
☐	Other:	

Family Structure

Family Members at Home

Name	Relationship	Age

Family Members Not at Home

Name	Relationship	Age

Family History of Mental Illness and/or traumatic events (known or suspected):

____

____

____

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____

Any additional information regarding child's current state and functioning, continue on back:

____

____

____

____

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____

______________________________ **Client Signature**	______________ **Date**
______________________________ **Custodial Parent/Legal Guardian Signature** (By signing, I confirm that all legal custodial parents are aware child is receiving treatment)	______________ **Date**