kiki erickson, licsw

integrative psychotherapist 206.200.1093

2743 California Ave., SW, Suite 301

Seattle, WA 98116

INTAKE FORM

NAME: _____

(Last) (First) (Middle Initial)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBERS: (H) _____ (W) _____ (C) _____

EMAIL ADDRESS: _____

ACCEPTABLE TO CONTACT YOU AND LEAVE A MESSAGE ON: (circle)

HOME PHONE Y N CELL PHONE Y N WORK Y N HOME MAIL Y N

EMAIL Y N (Please note: Email correspondence is not considered to be a confidential medium of communication.)

BIRTH DATE _____/_____/_____ BIRTH TIME _____

BIRTH CITY, STATE, COUNTRY _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____TELEPHONE: _____

CURRENT FAMILY SITUATION: (partners, spouses, children, roommates, extended family)

_____

_____

_____

_____

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INITIAL COMPLAINT OR CONCERN: _____

_____

_____

_____

DATE PROBLEM/CONCERN BEGAN: _____

BRIEF HISTORY OF THE PROBLEM/COMPLAINT: _____

_____

_____

_____

PREVIOUS THERAPY FOR THE PROBLEM/COMPAINT? (circle) Y N

IF YES, DATE(S) AND BRIEF DESCRIPTION. WAS IT HELPFUL? _____

_____

_____

CURRENT SYMPTOMS: (please check all that apply, and describe on reverse if indicated)

___ sleep problems ___ eating problems ___ concentration difficulties ___ loneliness

___ moody ___ sad ___angry ___ irritable ___ anxious ___ hopelessness

___ panic attack ___ cycling repetitive thoughts ___ recurring bad dreams

___weight changes (please describe):_____

___ increase in unhealthy or self-harming behaviors (please describe): _____

___ suicidal thoughts/wishing you were dead (please describe): _____

___ decrease in ability to have fun or enjoy typical pleasurable activities (please describe):

_____

___ increase in physical discomfort/pain (please describe): _____

___ changes in relationship(s) with family, friends, work (please describe): _____

ANY OTHER COMPLAINTS/PROBLEMS: _____

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RECENT IMPORTANT EVENTS/CHANGES IN LIFE OR LIVES OF SIGNIFICANT OTHERS:

_____

_____

_____

CURRENT MEDICAL CONDITION/CONCERNS: _____

_____

_____

PHYSICIAN(S) AND CONTACT NUMBERS: _____

_____

MEDICATIONS—PRESCRIBED AND OVER THE COUNTER (please list medication, condition, and amount taken): _____

_____

_____

_____

_____

Prescriber: _____

HOSPITALIZATIONS: (please list year and cause: _____

_____

Outcome:_____

RELATIONSHIP HISTORY (relationships/years/marriages/divorces/domestic partnerships):

_____

_____

_____

_____

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SUBSTANCE USE—ALCOHOL, DRUGS/STREET OR PRESCRIBED:

____ alcohol years used: _____

____ drugs frequency: _____ type(s): _____

history and changes in use:_____

_____

_____

____ member of 12-step program? sponsor?:_____

treatment (year/setting): _____

CURRENT SOURCES OF REJUVENATION, RELAXATION, PLAY: _____

_____

_____

_____

GOAL(S) FOR THERAPY: _____

_____

_____

_____

HOW WILL YOU KNOW THAT THERAPY IS COMPLETED? _____

_____

_____

_____ _____

(Client signature) (Date)