INTAKE FORM

Betsy L. Hicks, MA, LMFT
Lacey Couple & Family Therapy Services, PLLC
677 Woodland Sq Lp SE Suite 11 Lacey, WA 98503
(360) 588-2181

Name:____

Address:____

Phone number_____________________________ OK to call and leave a message? YES or NO

Date of Birth__________ Age:_____ Ethnicity______________________________________

Gender______________ Occupation____

Relationship Status: Single___ Married___ Divorced____ Separated___ Partnership___
Other_________________________

Referred by: Psychology Today/Google/ Personal Referral/Other _______________________
If someone referred you, do I have your permission to thank this person for the referral?
YES or NO ______(initial) (No additional information will be shared with this individual.)

(Please circle Yes or No to all applicable questions. If yes, please provide further information)

Health Issues____

Disabilities? YES or NO If yes, please describe_______________________________________

Current Medications? YES or NO If yes, please list:_______________________________

Military Affiliation? YES or NO If yes, please describe ________________________________

Please list any alcohol and/or substance use disorders, or illness in your family, including yourself:
Alcohol Use Disorder? YES/NO father/mother/siblings/self/other_______________________
Substance Use Disorder? YES/NO father/mother/siblings/self/other______________________
Mental illness? YES/NO father/mother/siblings/self.other______________________________
Serious illness? YES/NO father/mother/siblings/self/other______________________________

Is there a history of suicide in your family? YES or NO ______________________________
Have you ever attempted suicide? YES or NO_____________________________________
Do you currently feel suicidal or think about suicide? YES or NO _______________________
____

If you are seeking marriage/couples therapy is there current physical abuse? YES or NO
____
____

PAST/PRESENT THERAPY/COUNSELING (Please provide, approximant time frame, initial reason for therapy, and a brief description of the treatment to include how helpful it was, and how/why it ended)

____

SUPPORT (Friendships, significant relationships, community, spirituality, etc... Please list if you feel they are significant and briefly describe)

____

CURRENT SIGNIFICANT LIFE CHANGES or STRESSFUL EVENTS (Please describe)

____

CLINICAL INFORMATION (Briefly describe why you are currently seeking counseling)

____

INITIAL GOALS/HOPES (Briefly describe what you are hoping to achieve/learn/understand out of therapy)

____

Approximately how long have you been concerned about current reason you are seeking counseling ____________________________

Do you consider the severity of your issues(s) to be: Mild Moderate Severe

OTHER INFORMATION (Please add any other information you feel would be helpful for me to know about)

____

Clients Name____________________________ Date______________