Linda Scott MA, LPC

Confidential Intake Information

I. IDENTIFYING INFORMATION

Last Name First Name	MI Preferred name (if different)
Local Address (number and street) City	State Zip
Local Phone Number Cell Phone Number Work Phone Number	Email Address
Check above box for number at which we can contact you or leave a message. We will not identify ourselves or state why we are calling.	
Birth Date (M/D/Y) Age	Male □ Marital Status: Single □ Married □ Female □ Living Together □ Separated □ Divorced □
Disability Type : None □ Physical □ Learning □ Behavioral □ (Optional) Hearing □ Visual Other □	Name of Health Insurance Company
Contact in case of Emergency Name : Phone: Relationship:	Either MD or therapist who is treating you: Name: Phone: Profession:

II. Medical Information:

Do you have any medical problems? No Yes If yes please describe:

Are you currently taking prescribed, over-the-counter, or herbal medication? No Yes If yes, which ones?

Do you use alcohol/drugs now? No Yes If yes what kinds?	How much daily? How much weekly?
Have you ever had previous psychological counseling? No Yes If yes, when? With whom? For how long?	Have you ever been hospitalized for suicide attempt, drug or alcohol problems, or an emotional/behavioral problem? Yes N o If yes, where? When? For how long?

III. SERVICES SOUGHT

Please briefly describe why you are seeking services:

On a scale of 0 to 10, how distressed have you been during the last week? (Circle one)

0 1 2 3 4 5 6 7 8 9 1 0

None Some Extremely

Are you experiencing thoughts of suicide either at present or within the past two weeks? (Circle one) YES NO

As a result of therapy, what do you most want to accomplish, i.e., resolve, change, discover?

How did you find out about us? □ Referral □Friend □Self
□Family □ Phonebook □ Other

Please Sign and date: Date:
Signature:

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