Enliven | counseling therapy for couples & adults
Cultivate your connection. Enliven your life.™

Client Intake Form
Joel Freedman, MA, LMHCA

Please print clearly. If any question is difficult for you to answer, please let me know.

Full Name: ____________________________ Preferred Name: _________________ Gender: _________

Address: ____ City: ________________ Zip: __________

Birthdate: ______________ Age: ____ Phone Number: ________________ ☐ Cell ☐ Work ☐ Home

Who lives with you (*check all that apply*)? ☐ I live by myself ☐ Spouse/Partner ☐ Boyfriend/Girlfriend ☐ Children (# __) ☐ Parent(s)/In-law(s) ☐ Roommate(s) ☐ Pet(s) ☐ Other: ______________________

Emergency contact: ____
Name Relationship Phone no.

What led you to make an appointment to see me? ____

What are your goals for our work together? ____

How did you find me? ☐ Psychology Today ☐ On-line Search ☐ Professional Referral ☐ Friend/Family ☐ Other

Name: ______________________________________ May I thank them for their referral? ☐ Yes ☐ No

Highest education completed? ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ Any college ☐ AA ☐ BA/BS ☐ Post-Grad

Current relationship status: ____________________________ For how long? ________________________

How content are you with your relationship status? (*select one*)

1	2	3	4	5
Very Content	Content	Neutral	Discontent	Very Discontent

Current occupation: _________________________________ ☐ Full-time ☐ Part-time Since _________

How content are you in your occupation? (*select one*)

1	2	3	4	5
Very Content	Content	Neutral	Discontent	Very Discontent

Do you have a Primary Care Physician? ☐ Yes ☐ No When did you last see a PCP? _______________

Name: _____________________________ Address/City Location: _______________________________

Are you currently receiving medical treatment? ☐ No ☐ Yes Details: _____________________________

What medications/supplements are you taking? ____

Have you seen a therapist, psychologist, or psychiatrist before? ☐ No ☐ Yes When? _______________

If yes, for what purpose/concern? ____

Have you been prescribed medication for a mental health concern before? ☐ Yes ☐ No

If yes, please describe: ____

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Any suicidal thoughts today? ☐ Yes ☐ No In the past? ☐ Yes ☐ No Ever attempted suicide? ☐ Yes ☐ No

Have you physically hurt yourself or others? ☐ No ☐ Yes Details: ______________________________

Has anyone physically hurt you in the past year? ☐ Yes ☐ No Do you currently feel safe? ☐ No ☐ Yes

Details: ____

I use… alcohol: ☐ Daily ☐ Once a week or more ☐ Once a month or more ☐ Rarely ☐ Never
cannabis: ☐ Daily ☐ Once a week or more ☐ Once a month or more ☐ Rarely ☐ Never
tobacco: ☐ Daily ☐ Once a week or more ☐ Once a month or more ☐ Rarely ☐ Never
other drugs: ☐ Daily ☐ Once a week or more ☐ Once a month or more ☐ Rarely ☐ Never

Does your use of any of these raise concerns for you at home, at work, or socially? ☐ Yes ☐ No

Please check the boxes below if you have or have had concerns with any of the following:

Concern			Concern		
Aggressiveness	☐ Present	☐ Past	Hearing noises/voices	☐ Present	☐ Past
Aging-related issues	☐ Present	☐ Past	Hopelessness	☐ Present	☐ Past
Alcohol use	☐ Present	☐ Past	Legal worries	☐ Present	☐ Past
Anger	☐ Present	☐ Past	Impulsive behavior	☐ Present	☐ Past
Anxiety	☐ Present	☐ Past	Loneliness	☐ Present	☐ Past
Apathy	☐ Present	☐ Past	Loss of control	☐ Present	☐ Past
Bad dreams	☐ Present	☐ Past	Memory issues	☐ Present	☐ Past
Cannabis use	☐ Present	☐ Past	Monogamy/Polyamory	☐ Present	☐ Past
Changes in appetite	☐ Present	☐ Past	Nervousness	☐ Present	☐ Past
Communication	☐ Present	☐ Past	Pain	☐ Present	☐ Past
Decision-making	☐ Present	☐ Past	Panic	☐ Present	☐ Past
Depression	☐ Present	☐ Past	Parenting issues	☐ Present	☐ Past
Difficulty breathing	☐ Present	☐ Past	Physical abuse	☐ Present	☐ Past
Difficulty focusing	☐ Present	☐ Past	Racing thoughts	☐ Present	☐ Past
Difficulty relaxing	☐ Present	☐ Past	Rapid heart rate	☐ Present	☐ Past
Difficulty sleeping	☐ Present	☐ Past	Relationship issues	☐ Present	☐ Past
Digestive upset	☐ Present	☐ Past	Sadness	☐ Present	☐ Past
Divorce/Separation	☐ Present	☐ Past	Seeing things	☐ Present	☐ Past
Dizziness	☐ Present	☐ Past	Self-harm (cutting, etc.)	☐ Present	☐ Past
Drug use	☐ Present	☐ Past	Serious illness	☐ Present	☐ Past
Eating issues	☐ Present	☐ Past	Sex/Sexuality	☐ Present	☐ Past
Emotional abuse	☐ Present	☐ Past	Sexual abuse	☐ Present	☐ Past
Fatigue	☐ Present	☐ Past	Stress	☐ Present	☐ Past
Fear	☐ Present	☐ Past	Trauma	☐ Present	☐ Past
Fertility/Infertility	☐ Present	☐ Past	Trust/Loss of trust	☐ Present	☐ Past
Fidelity/Infidelity	☐ Present	☐ Past	Unhappiness	☐ Present	☐ Past
Financial worries	☐ Present	☐ Past	Unwanted thoughts	☐ Present	☐ Past
Grief/Loss	☐ Present	☐ Past	Verbal abuse	☐ Present	☐ Past
Guilt/Shame	☐ Present	☐ Past	Withdrawal/Isolation	☐ Present	☐ Past
Headaches	☐ Present	☐ Past	Work worries	☐ Present	☐ Past

Anything else you'd like me to know? ______________________________

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