CLIENT INTAKE AND BACKGROUND FORM
SARAH A. LEFFLER, MSW, LCSW, LLC

NAME:_____ PREFERRED/NICKNAME:_____ DOB:_____ Age: _____

ADDRESS: _____

PHONE:_____ Home Cell Work Can I leave a message at this number? ☐ Yes ☐ No

EMAIL: _____ OCCUPATION: _____

Can I use email to reach you for logistical / scheduling purposes? ☐ Yes ☐ No

EMERGENCY CONTACT/RELATION TO YOU:_____ PHONE: _____

RELATIONSHIP HISTORY:

PRESENT RELATIONSHIP STATUS (check all that apply): ☐ Single ☐ Living Together ☐ Engaged ☐ Married
☐ Living Apart ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed ☐ Dating

Length of time in current relationship: _____

Were there any previous marriages/long-term relationships? ☐ Yes ☐ No How Many?_____ Duration of Each: _____

CHILDREN FROM *THIS* RELATIONSHIP (use back of form if additional space is needed):

Name	Gender	DOB	Age/Grade	Where/with whom do they live?

CHILDREN FROM *PRIOR* RELATIONSHIPS (use back of form if additional space is needed):

Name	Gender	DOB	Age/Grade	Where/with whom do they live?

OTHERS CURRENTLY LIVING IN YOUR HOME: _____

MEDICAL AND MENTAL HEALTH HISTORY:

Please list any known medical issues, either current or past: _____

Are you currently taking prescription or over the counter medication? ☐ Yes ☐ No If yes, provide current medication list below:

Medication	Dosage	Prescribed / Used For	Prescribing MD (if not over the counter)

Do you engage in any substance use on a regular basis? ☐ Yes ☐ No Type/Amount per day: _____

How much alcohol do you drink and how often? _____
Amount Per Day Frequency (Days/Week)

Have you ever experienced thoughts of suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No Have you ever been hospitalized for this? ☐ Yes ☐ No

Please list, if any, hospitalizations and/or treatment programs attended for mental health issues:_____

_____

COUNSELING TOPICS and EXPERIENCE:

Have you had previous counseling experience? ☐ Yes ☐ No If Yes, describe below:

Dates (From-To)	Issues/Concerns Addressed	Helpful?	
		Yes	No
		Yes	No