Heath Collins, LCSW
http://www.HeathCollinsTherapy.com
512-903-0606
HCollins.LCSW@gmail.com

# Client Intake Form

## Contact Information

**Full Name:** _____ **Home Address:** _____

**Date of Birth:** _____ _____

**Gender:** _____

**Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

**Telephone: (H)** _____ **(C)** _____ **(W)** _____

It is acceptable to leave a confidential voicemail on the following phones (Home, Cell, Work): _____

**Email:** _____

*Note: Communication by email does not ensure confidentiality.*

**Referral Source:** _____ **Insurance Provider:** _____

**What prompted you to seek therapy today?**

_____

_____

_____

**Have you participated in therapy for this issue before?**

_____

_____

## History

Have you or a family member experienced any of the following?

| | Yes/No | Self or Family Member(s)? | Please Explain |
|---|---|---|---|
| Substance Abuse | | | |
| Domestic Violence | | | |
| Self-Injury | | | |
| Suicide Attempts* | | | |
| Criminal Involvement | | | |
| Other Trauma | | | |

* If yourself, number of attempts? _____ Date of Last Attempt _____

Did you receive treatment? _____ If so, where? _____

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Are you currently feeling suicidal? _____ Have you felt suicidal during the past 6 months? _____

**During the past TWO weeks, have you experienced any of the following?**

| | Yes/No | Please Explain |
|---|---|---|
| Depression | | |
| Anger | | |
| Anxiety | | |
| Panic Attacks | | |
| Unexplained Aches/Pains | | |
| Desire to Hurt Yourself | | |
| Difficulty Sleeping | | |
| Feeling Detached | | |
| Substance Abuse | | |

**Are you experiencing any other symptoms that you would like for me to know about?**

_____

_____

_____

**What would you like to get out of therapy?**

_____

_____

_____

**What coping strategies do you currently use when dealing with difficult emotions?**

_____

_____

_____

**Is there anything else that you would like for me to know?**

_____

_____