Glenn King, MA, LMHC

3301 Burke Ave N. #220
Seattle, WA 98103
206.486.0984

Intake Form

Name _____
(first) (last) (middle initial)

Birth Date _____ /_____ /_____ Age _____ Gender ☐ male ☐ female

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Address: _____
(street and number)

_____
(city) (state) (zip)

Home Phone: ( ) May I call and leave a message? ☐Yes ☐ No

Work Phone: ( ) May I call and leave a message? ☐Yes ☐ No

E-mail: _____ May I e-mail you? ☐Yes ☐ No
*E-mail is not considered a confidential means of communication

If "no" to all three then how can I contact/leave a message? _____

_____

Have you previously received mental health services (counselor, psychologist psychiatrist)?
☐ No
☐ Yes, previous therapist/practitioner: _____

Date of treatment: _____

Focus of treatment: _____

_____

Are you currently taking any prescription medication?

☐No

☐Yes, please list: _____

_____

Have you ever taken any psychiatric medication?

☐No

☐Yes, please list and provide dates: _____

_____

General Health and Mental Health Information

Name of Personal Physician/Clinic: _____

Physician Phone Number: _____

1. How would you rate your overall health?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any specific health problems you are having: _____

_____

2. How would you rate your current sleep habits?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

3. Are you currently engaging in physical activity?

☐No

☐Yes _____ days per week. Type of exercise _____

4. Please list any difficulties with eating patterns or appetite: _____

_____

5. Are you currently experiencing intense anxiety, panic attacks or phobias?

☐No

☐Yes, this began _____

_____

6. Are you currently experiencing overwhelming grief, sadness or depression?

☐No

☐Yes, this began _____

_____

7. What stressful events or life changes have you experienced lately? _____

_____

_____

Current Symptoms

Please check any of the following that pertain to you

☐Anxiety	☐Elevated Mood	☐Mania	☐Poor Impulse Control
☐Anger	☐Grief/Loss	☐Memory Issues	☐Poor Self-Esteem
☐Appetite Disturbance	☐Guilt	☐Obsessions	☐Purging
☐Binging	☐Hallucinations	☐Oppositional	☐Self-injury (cutting)
☐Compulsions	☐Hopelessness	☐Panic Attacks	☐Sleep Disturbance
☐Decreased Energy	☐Hyperactivity	☐Paranoia	☐Weight gain/loss
☐Depression	☐Irritable	☐Poor Concentration	☐Withdrawn

Other: _____

Current Functioning

☐Noticeable decrease in productivity	☐Medication misuse or non-compliance
☐Fewer social contacts	☐Argumentative/Verbal Hostility
☐Decrease in care to children	☐Absent 2 days or more from school/work
☐Drop in grades (if applicable)	☐Medical LOA due to psychiatric problem
☐Suspension from work/school	☐Difficulty finding motivation

Family Mental Health History

In the section below please identify if there is a family history of any of the following. If yes, please list the family member's relationship to you (mother, father, uncle grandmother, etc).

	Please check	List of all Family Members Affected
Alcohol/Substance Abuse	☐Yes ☐ No	
Anxiety	☐Yes ☐ No	
Bipolar	☐Yes ☐ No	
Depression	☐Yes ☐ No	
Domestic Violence	☐Yes ☐ No	
Eating Disorder	☐Yes ☐ No	
Obsessive Compulsive Disorder	☐Yes ☐ No	
Schizophrenia	☐Yes ☐ No	
Suicide Attempts	☐Yes ☐ No	

Additional Information

1. Are you currently employed? ☐No ☐Yes

If yes, please describe employment situation: _____

_____

Please describe any work related stressors: _____

_____

2. Do you consider yourself to be spiritual or religious? ☐No ☐Yes

If yes, please describe your faith or belief : _____

_____

3. Are you currently in a romantic relationship? ☐No ☐Yes

If yes, for how long? _____

On a scale from 1-10, how would you rate your relationship? _____

4. What do you consider to be some of your strengths? _____

_____

5. What would you like to accomplish by the end of therapy? _____

_____

_____

Emergency Notification

Name _____
(First) (Last) (Middle Initial)

Address _____
(street number)

_____
(city) (state) (zip)

Phone ( ) Relationship _____

Client Signature

_____ _____
Client Signature (for those 13 years or older) Date

_____ _____
Parent/Guardian Signature (younger than 13) Date