

## Individual Intake Form

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[www.wendysmithcounseling.com](http://www.wendysmithcounseling.com)

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_. Okay to leave a message? Yes\_\_\_ No\_\_\_

Work phone: \_\_\_\_\_. Okay to leave a message? Yes\_\_\_ No\_\_\_

Cell phone: \_\_\_\_\_. Okay to leave a message? Yes\_\_\_ No\_\_\_

Please circle preferred phone for contact.

How did you find out about me or who referred you? \_\_\_\_\_

Occupation: \_\_\_\_\_

Religious affiliation, if any: \_\_\_\_\_

Ethnic/ racial/ national/ indigenous heritage: \_\_\_\_\_  
\_\_\_\_\_

Other way you identify yourself that is important to you: \_\_\_\_\_  
\_\_\_\_\_

Emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who else (if anyone) lives in your household (i.e., roommate, partner, children, dog)?  
\_\_\_\_\_

What is your relationship status (i.e., single, partnered, widowed, divorced, other)?

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Are you presently suing anyone or thinking of suing anyone, involved in, or likely to be involved in, a custody case, or otherwise involved with the legal or court systems? Yes\_\_\_ No\_\_\_

Have you ever received counseling, psychiatric, or drug or alcohol treatment before? Y\_\_ N\_\_  
If yes, please explain:

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Have you ever been hospitalized for psychiatric reasons? Yes\_\_\_ No\_\_\_  
If yes, please explain:

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Who is your primary care doctor and/or where do you receive medical treatment?

Doctor: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

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If you are being treated by a psychiatrist, who is your psychiatrist?

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me, may I tell your doctor(s) so that he/she/they can be fully informed and we can coordinate treatment, if necessary? Yes\_\_\_ No\_\_\_

Comments: \_\_\_\_\_

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Please list any physical health problems you currently have and how long you have had them:

Please list any disabilities of any kind that you have and how long you have had them:

Please list all prescription medications you currently take, followed by over-the-counter medications and supplements. Include dosage per day and reason:

Please complete the following table regarding your chemical use:

Substance	Check all that apply	How often? (specify amount per day or per week)
Coffee		
Tea		
Pop/ soda		
Energy drinks		
Beer, wine		
Hard liquor		
Tobacco		
Cannabis, marijuana, pot, weed		
Methamphetamine		
Heroin		
Cocaine, crack cocaine		
Inhalants (glue, paint thinner, gasoline)		
Other similar substances 1.  2.  3.		