

Hannah Herkert, MA, LMHC
206-636-1235
www.hannahherkercounseling.com
120 Cedar Avenue, Suite 201
Snohomish, WA 98290

Client Intake Form – Child/Adolescent

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Sex _____ Gender/Preferred Pronouns _____

Parent / Legal Guardian (If under 18) _____

Parent / Legal Guardian (If under 18) _____

Address _____

Contact Phone Number(s) Cell _____

Other _____

Contact E-Mail Address _____

School Name _____

Grade _____ 504 Plan? IEP? Other Special Services? _____

Extra Curricular Activities/Hobbies _____

Ethnicity _____ Religion _____

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Are you currently working with a physician, psychiatrist, or other healthcare provider?

Name & Practice Name _____

Would you like me to coordinate with this provider? Yes No

Client Health History

History of Mental Health Services - list age(s) & provider:

History of Psychiatric medication Yes No

List:

Current Medications: _____

Previous Mental Health diagnosis:

Relevant Medical Diagnosis: _____

History of alcohol / drug use? Yes No Describe: _____

Has the client ever been hospitalized for psychiatric reasons? Yes No

If yes, when? _____

Has the client ever made a plan to commit suicide or attempted suicide?

Yes No If yes, when? _____

Does the client currently have thoughts of ending their life? Yes No

Please list any serious allergies _____

Please list additional information you would like me to know:

Client Interest in Counseling Services

Please describe what brings you (or your child/teen) to counseling:

Please check following symptoms or issues that apply to the client:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Behavior at home |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Behavior at school |
| <input type="checkbox"/> Drug/Alcohol Use | <input type="checkbox"/> Anger | <input type="checkbox"/> Worry/Fear |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Abuse | <input type="checkbox"/> Strained relationship(s) |
| <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Cutting/Self-Harm | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Health Concern | <input type="checkbox"/> Life Change | <input type="checkbox"/> Grief and Loss |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Trauma | <input type="checkbox"/> Decision Making/self control |
| <input type="checkbox"/> Focus/Attention | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Divorce/Separation |

Please describe client's thoughts about seeing a therapist:
