



Client Intake Form

Welcome to Affirming Words LLC. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions in helping you meet your wellness goals. Please note, this information is confidential, for our use only, and will not be released to anyone without your written permission.

Personal Information

Client Name: _____ Date of Birth: _____ Age: _____
SSN: _____

Street Address: _____

City/State _____ : Zip Code: _____

Sex: Female Male Transgender M to F Transgender F to M

Religious Affiliation (if any): _____

Cell Phone: _____ Is it okay to leave a message? Yes No

Email Address: _____ May we e-mail you? Yes No

In an emergency, who do we call?

Contact Name: _____ Contact Phone: _____ Relationship: _____

Social / Family Information

Which best describes you? Choose all that apply: Never Married Married Separated
Divorced Widowed Engaged Living Together Same-Sex Partner

If you are currently in a romantic relationship, for how long? _____. On a scale of 1 to 10 (with 10 being best), how would you rate your satisfaction with your current relationship? _____

Do you have children? If so, please provide names and ages: _____

If you have listed children, with whom do they live? _____

Medical and Mental Health History / Information

Are you currently being treated by a physician for any medical conditions? If so, please describe: _____

Are you currently taking prescription, over-the-counter or herbal medication? No Yes



Medication name/dose: _____

Have you ever seen a Psychiatrist or other mental health provider? No Yes If yes, when? _____
What was the focus of treatment? _____ Was it helpful? Yes No

Counseling Concerns

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

1. _____ 3. _____
2. _____ 4. _____

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/friends)? Has anything been helpful? _____

What are some of your coping strategies? _____

What do you consider to be your strengths? _____

Counseling Goals

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1. _____ 3. _____
2. _____ 4. _____

Risk Assessment

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis:

Please list family, friends, support groups and community groups which are helpful to you: _____

List any personal history of emotional, physical, and/or sexual abuse: _____

Has a family member or close friend ever committed suicide? No Yes, (who) _____

Have you been having any thoughts of harming yourself or others? No Yes, Self Other(s)



Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state who and under what circumstances: _____

Alcohol/Substance Use Survey

How often do you have a drink containing alcohol?

Never 1x/month or less 2-4x/month 2-4x/week More than 4x/week

How many drinks containing alcohol do you consume on a typical day that you are drinking?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

Do you use marijuana or other "street drugs"? No Yes; What type/quantity/frequency of use: _____

Referral Source

How did you learn about this practice? (Please check one and provide name as indicated):

Advertising (Source): _____ Internet: _____ Friend: _____ Other: _____

Client Services Agreement

Name of Client: _____ Name of Responsible Party (if different): _____

TREATMENT: I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. My signature below indicates my desire and consent to receive services from Affirming Words LLC.

PAYMENT: I understand that I (the client) am fully responsible for the payment of all fees for services provided. I understand that it is Affirming Words policy that the fee for any session is payable at the beginning of the session. Affirming Words does not accept insurance. Payments can be made in cash, check, PayPal, or credit card, in person or through the Affirming Words website payment portal. All therapy services are 50 minutes in length at a rate of \$110. In the event that I do not cancel an appointment within 24 hours and my appointment cannot be rescheduled that same week, I acknowledge I may be subject to a \$50 cancellation fee. My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment Policy.

Client (or responsible party's) signature: _____ Date: _____