Five One Two Counseling

Shaina Singh, LCSW, CCM

Confidential Client Intake Form

Date:_____

Name:_____

Address:_____

City, State, Zip:_____

Preferred Phone # :_____ _____ Other Phone:_____

E-mail address:_____ Referred By: _____

Age:_____ Birth Date:_____ Gender:_____

Ethnic Background: _____ Relationship Status:_____ ___

Occupation:_____ Employer:_____

Name(s) of previous therapist(s) and dates seen:_____

_____

Describe any health concerns:_____

_____

List medications you currently use:_____

Psychotropic medications you have used in the past:_____

_____

Please describe what brings you here today:_____

_____

_____

_____

_____

Please check any of the following items that concern you:

_____ Self-esteem, self-confidence
_____ Anxiety, nervousness, fears
_____ Depression
_____ Sexual concerns
_____ Angry, hostile feelings
_____ Traumatic experience
_____ Physical distress
_____ Eating or appetite problems
_____ Alcohol or drug problems
_____ Sleep problems
_____ Parent–child problems
_____ Survivor of abuse or neglect
_____ Other: _____

_____ Family conflicts or pressures
_____ Friendship conflicts
_____ Relationship/marital concerns
_____ Shyness, being assertive
_____ Loneliness
_____ Procrastination or motivation
_____ Gay/Lesbian issues
_____ Suicidal feelings or behaviors
_____ Stress
_____ Excessive gaming or Internet use
_____ Health problems
_____ Self-control
_____ Work or career concerns

Have you had thoughts of suicide in the past? _____

Any previous attempts?_____

Have you had thoughts of harming people, property or animals in the past month?

_____

Please list any non-prescribed substances you are using. Please describe any current use (frequency, amount etc)-

_____

Shaina Singh, LCSW, CCM

_____

Please list the members of your immediate family (include parents, siblings, spouse/partner, children, and all others in your home) and others who are of a significant relationship to you:

Name	Relationship	Age	Occupation	City/State

_____

_____

_____

_____

_____

AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of therapy and counseling care. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

I,_____ , request and authorize:

_____ (Phone)_____

(Name)

_____

(Address)

to release to: Shaina Singh, LCSW, CCM 906 E. 5th St # 201. Austin, TX 78702

Shaina Singh, LCSW, CCM

Authorization to Release information

If you want your information released to anyone else (support system, significant other, parent etc.)

I hereby authorize Shaina Singh, LCSW to discuss information relevant to my treatment to the person or agency named below.

1._____

Relationship to client:_____

2._____

Relationship to client:_____

Signed: _____ Date Signed:_____

Printed Name:_____

Shaina Singh, LCSW, CCM