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www.charissawalson.com

cwalson@charissawalson.com

7808 Pacific Ave.- Suite 8- Tacoma WA 98408

ph: 206-747-9604

### **Confidential Client Intake Form**

#### **Contact Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

E-mail: \_\_\_\_\_ May I contact you by email? \_\_\_\_\_

May I send information by mail? \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/Studying: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### **Family Information**

Marital Status: Single Engaged Married Divorced Separated Living Together Remarried Widowed

Spouse/Partner Name \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

Are your parents living? \_\_\_\_\_

#### **Health History**

Please indicate your major stressors over the last 12 months:

\_\_\_ Serious illness or injury \_\_\_ Death of a close friend or family member

\_\_\_ Job change/other transition \_\_\_ Major illness in family \_\_\_ Gain of a new family member

\_\_\_ Relationship issues/divorce/separation

Other (please elaborate) \_\_\_\_\_

Have you ever received psychological or psychiatric counseling before? \_\_\_ Yes \_\_\_ No

When? From Whom? Purpose? Results?

Are you currently taking any medications? \_\_\_ Yes \_\_\_ No

Please describe: \_\_\_\_\_

Have you ever been hospitalized for a psychiatric or emotional health reason? \_\_\_ Yes \_\_\_ No

When? Where? For What Reason? Outcome?

Physician's name, address and phone number: \_\_\_\_\_

Have you ever attempted or considered suicide? \_\_\_ Yes \_\_\_ No

Do you or have you practiced in cutting? \_\_\_ Yes \_\_\_ No

How significant a role does spirituality play in your life?

\_\_\_ None \_\_\_ Somewhat important \_\_\_ Significant \_\_\_ Very significant

How did you hear about Karis Wellness?

\_\_\_ google search \_\_\_ yellowpages \_\_\_ website \_\_\_ referral \_\_\_ psychology today \_\_\_ networktherapy \_\_\_ other