

INTAKE FORM

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(360) 588-2181

Name: _____

Address: _____

Phone number _____ OK to call and leave a message? YES or NO

Date of Birth _____ Age: _____ Ethnicity _____

Gender _____ Occupation _____

Relationship Status: Single ___ Married ___ Divorced ___ Separated ___ Partnership ___
Other _____

Referred by: Psychology Today/Google/ Personal Referral/Other _____

If someone referred you, do I have your permission to thank this person for the referral?

YES or NO _____ (initial) (No additional information will be shared with this individual.)

(Please circle Yes or No to all applicable questions. If yes, please provide further information)

Health Issues _____

Disabilities? YES or NO If yes, please describe _____

Current Medications? YES or NO If yes, please list: _____

Military Affiliation? YES or NO If yes, please describe _____

Please list any alcohol and/or substance use disorders, or illness in your family, including yourself:

Alcohol Use Disorder? YES/NO father/mother/siblings/self/other _____

Substance Use Disorder? YES/NO father/mother/siblings/self/other _____

Mental illness? YES/NO father/mother/siblings/self/other _____

Serious illness? YES/NO father/mother/siblings/self/other _____

Is there a history of suicide in your family? YES or NO _____

Have you ever attempted suicide? YES or NO _____

Do you currently feel suicidal or think about suicide? YES or NO _____

If you are seeking marriage/couples therapy is there current physical abuse? YES or NO

PAST/PRESENT THERAPY/COUNSELING (Please provide, approximat time frame, initial reason for therapy, and a brief description of the treatment to include how helpful it was, and how/why it ended)

SUPPORT (Friendships, significant relationships, community, spirituality, etc... Please list if you feel they are significant and briefly describe)

CURRENT SIGNIFICANT LIFE CHANGES or STRESSFUL EVENTS (Please describe)

CLINICAL INFORMATION (Briefly describe why you are currently seeking counseling)

INITIAL GOALS/HOPES (Briefly describe what you are hoping to achieve/learn/understand out of therapy)

Approximately how long have you been concerned about current reason you are seeking counseling _____

Do you consider the severity of your issues(s) to be: Mild Moderate Severe

OTHER INFORMATION (Please add any other information you feel would be helpful for me to know about)

Clients Name _____ Date _____