

# At the Heart of the Matter Counseling

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## Client Intake Form

### Client Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Phone: \_\_\_\_\_ Additional number: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

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

### Background Information

1. Have you ever participated in therapy before? \_\_\_yes \_\_\_no  
If yes, when? \_\_\_\_\_ Reason: \_\_\_\_\_
2. Are you currently seeing a psychiatrist, therapist, or counselor in addition to myself?  
\_\_\_yes \_\_\_no If yes, who? \_\_\_\_\_
3. Have you or a family member ever been hospitalized for mental or emotional illness?  
\_\_\_yes \_\_\_no If yes, please explain (dates, where, reason):  
\_\_\_\_\_  
\_\_\_\_\_
4. Have you ever been diagnosed with a mental health condition or illness? \_\_\_yes \_\_\_no  
If yes, please explain: \_\_\_\_\_
5. Have you been previously treated for any mental health issues or illness? \_\_\_yes \_\_\_no  
If yes, please explain: \_\_\_\_\_
6. Do you have a history of substance abuse/addiction? \_\_\_yes \_\_\_no  
If yes, please explain: \_\_\_\_\_
7. Do you have a legal history including arrests or prison? \_\_\_yes \_\_\_no  
If yes, please explain: \_\_\_\_\_

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8. Are you currently on any medications? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

9. Please list your Primary Care Provider: \_\_\_\_\_

10. Do you have any conditions or medical history that I should be aware of? \_\_\_ yes \_\_\_ no

If yes, please describe: \_\_\_\_\_

## Treatment Plan

1. Please tell me in your own words what brings you in today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What are your 2 most important goals for therapy?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___ marriage	___ divorce/separation	___ alcohol/drugs	
___ pre-marital	___ child custody	___ other addictions	
___ being single	___ disabled	___ grief/loss	___ past hurts
___ sexual issues	___ work/career	___ depression	___ codependency
___ family	___ school/learning	___ fear/anxiety	___ intimacy
___ children	___ money/budgeting	___ anger control	___ communication
___ parents	___ aging/dependency	___ loneliness	___ self-esteem
___ in-laws	___ mood swings	___ stress control	

4. Current Relationship Status: \_\_\_\_\_

5. I would describe my relationship with my friends as: \_\_\_\_\_

6. I would describe my relationship with my family as: \_\_\_\_\_

7. Please include any additional information you would like me to know: