Heron Counseling
TINA SHEA, MA, LPC

Client Intake Form

Date: _____

Name:_____ DOB:_____

Address:_____

_____

Phone: _____ Text: yes / no Voicemail: yes / no

Email: _____

If client is a minor, please provide information for legal guardian:

Name:_____ DOB:_____

Address:_____

_____

Phone: _____ Text: yes / no Voicemail: yes / no

Email: _____

Notable Medical History/Conditions:

_____

_____

_____

Current Medications: _____

_____

_____

Have you previously participated in counseling: yes / no

If yes, with whom? _____

*All information to be kept confidential unless otherwise noted by client

Previous Diagnoses: _____

Please rate the following areas of your life from 1-10; 1 being extremely unsatisfied, 10 being extremely satisfied.

How satisfied are you with…

- Your romantic relationship _____
- Your friendships _____
- Your family relationships _____
- Your work _____
- Your activity level _____

- Your ability to enjoy life _____
- Your ability to communicate with others _____
- Your ability to manage emotions _____
- Your sleep habits _____
- Your diet _____

What would you like out of your experience with counseling?

_____

_____

_____

_____

Comments:

*All information to be kept confidential unless otherwise noted by client