

Paulette de Coriolis, MA, LMHCA
Mental Health Counselor

Client Intake
(please print)

Today's Date: _____

Client Information

Full Legal Name: _____ Date of Birth: _____

Preferred Name: _____

How did you hear about me? _____

May I mention your name when I thank them for the referral? Y / N / NA

Medical Information

Please list any medical conditions you are being treated for: _____

Please list any medications you are taking, including psychiatric medications: _____

Primary Care Provider: _____ Phone Number: _____

Counseling Information

Have you ever been treated by a psychiatrist, counselor, or other mental health provider? Y / N

If Yes, Name: _____ Phone Number: _____

When did you receive this treatment? (approximate month/year & duration): _____

Please briefly describe the reason(s) for this prior treatment: _____

Do you have any family members with a history of mental illness or substance abuse? Y / N

If yes, please describe: _____

Are you, or is someone close to you, concerned about your use of alcohol or drugs? Y / N

Have you recently had any thoughts of harming yourself or someone else? Y / N

Briefly, what brings you to counseling today? _____

Client Signature _____ Date _____

phone: 425-417-3525
web: paulettcounseling.com
email: paulette@paulettcounseling.com

Paulette de Coriolis Counseling, PLLC
15600 Redmond Way, Suite 201
Redmond, WA 98052