Paulette de Coriolis, MA, LMHC
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: ______________________________

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

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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? ____

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Client Signature ____ Date __________________

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