Peek Counseling, PLLC
INTAKE FORM FOR ADULT

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. Please provide as much information as possible.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Client Information:
Client's Name: _____
Gender: _____ Client's Birthdate: _____
Pronouns:_____

Client's Address: _____

City: _____ State:_____ Zip Code: _____

May Katie Bisbee-Peek with Peek Counseling contact you at this address: ☐ YES ☐ NO

Home Telephone: _____ Cell Phone: _____Work Phone: _____

May Katie Bisbee-Peek with Peek Counseling contact you at all the above telephone numbers provided: ☐ YES ☐ NO

May Katie Bisbee-Peek with Peek Counseling leave a voice message at all the above telephone numbers provided: ☐ YES ☐ NO

Email Address: _____ Do you share this email address with anyone else?
If so please list who else shares the email address: _____

May Katie Bisbee with Peek Counseling contact you at the above email address: ☐ YES ☐ NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Katie Bisbee-Peek with Peek Counseling to contact you by email you are consenting to receive electronic communications and understand the risks involved. Peek Counseling cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication:

□Telephone (H) □ Cell Phone, including texts □ Telephone (W) □ Email

Client's Occupation: _____

Number of Months at this Occupation: _____

Marital Status: ☐ Single ☐ Married or Civil Union ☐ Separated ☐ Divorced ☐ Living Together

Do you have any children: ☐ YES ☐ NO How many? _____ Ages:_____

It is the policy of Peek Counseling not to treat any of your children while providing mental health services to you. It is not within Katie Bisbee-Peek with Peek Counseling's scope of practice to provide recommendation for custody arrangements.

Emergency Contact Information:
In case of an emergency, Katie Bisbee-Peek with Peek Counseling may be required to contact someone on your behalf. Please list your emergency contact below, which Katie Bisbee-Peek with Peek Counseling may contact on your behalf. Katie Bisbee-Peek with Peek Counseling will only share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: _____

Telephone Number: _____

Relationship to Client: _____

Primary Care Physician Information:
In order to provide you with continuous and congruent care, Katie Bisbee-Peek with Peek Counseling may need to contact your primary care physician. Any contact that Katie Bisbee-Peek with Peek Counseling may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Last Physical: _____

May Katie Bisbee-Peek with Peek Counseling contact your physician: ☐ YES ☐ NO

Please list any medication you are currently taking (if you are not currently taking any medications, please state that you are not currently taking any medications):
_____

_____

_____

Please list any current physical illnesses, issues, and/or ailments you have (if you do not currently have any physical illnesses, issues, and/or ailments, please state so):

_____

_____

_____

Previous/Current Mental Health Provider(s):

In order to provide you with continuous and congruent care, Katie Bisbee-Peek with Peek Counseling may need to contact your previous or current Mental Health Provider. Any contact that Katie Bisbee-Peek with Peek Counseling may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Last Session: _____

May Katie Bisbee-Peek with Peek Counseling contact your previous or current Mental Health Provider: ☐ YES ☐ NO

Are you currently in counseling with the above listed mental health provider: ☐ YES ☐ NO

Have you ever sought counseling before: ☐ YES ☐ NO

If yes, please list your reason(s) for seeking mental health services (if you are currently seeing another mental health provider, please list the reason(s) here as well):

_____

_____

_____

Client's Mental Health:

Please tell us why you are seeking counseling and describe any issues/problems that led you to seek counseling:

_____

_____

_____

_____

_____

How have you dealt with these issues/problems in the past:

_____

_____

_____

Please list any past or current psychological illnesses or other mental health issues:

_____

_____

_____

Have you ever been, or are you currently, suicidal:

_____

Have you ever attempted to commit suicide:

_____

Has anyone in your family ever attempted or committed suicide:

_____

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones):

_____

_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate the mental illness): ☐ YES ☐ NO

_____

_____

Are you currently involved in any civil or criminal legal proceedings: ☐ YES ☐ NO
If yes, please state the circumstance(s):

_____

_____

Is there anything else you would like Katie Bisbee-Peek with Peek Counseling to know:

_____

_____

What would you like to accomplish through therapy and/or what goes would you like to achieve?

_____

_____

_____

Financial Information:

Will you need receipts for your insurance company: ☐ YES ☐ NO

2. Do you intend on a third-party (besides an insurance company) paying for counseling services:
☐ YES ☐ NO

If yes, please provide the following information:

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Relationship to Client: _____

3. Do you intend on paying for counseling services on your own: ☐ YES ☐ NO

Client Affirmation:
By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____ _____
Client Signature Date

Checklist of Concerns:

Client Name:_____

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also "Weight and diet issues")			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			

Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Housework/chores—quality, schedules, sharing duties			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Parenting, child management, single parenthood			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems (see also “Career concerns ...”)			

Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (You or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			
Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition			

❑ Other concerns or issues:

_____

_____

_____

_____

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____ _____

Client Signature Date