MOSAIC COUNSELING

Client Intake Profile

Personal Information

Last Name: _____ First Name: _____ Middle Name: _____

What is your preferred name: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Date of Birth (Mo./Day/Yr.): _____ Age: _____ Sex: Male ☐ Female ☐

Please list phone numbers where the counselor may contact you:

Home: (____)_____ May we leave a message? Yes ☐ No ☐

Work: (____)_____ May we leave a message? Yes ☐ No ☐

Cell: (____)_____ May we leave a message and text you? Yes ☐ No ☐

Email _____ May we email you? Yes ☐ No ☐

Please note email correspondence is not considered to be a confidential medium of communication

Who may we contact in case of emergency (list phone number and relationship):

_____

_____

Referral Source (Check all that apply):

☐ Mosaic Website
☐ Other Website: _____
☐ Insurance Company
☐ Doctor: _____
☐ Employer: _____
☐ Church: _____
☐ Friend/Family Member
☐ Psychology Today
☐ Other: _____

Request for Counseling

In your estimation, what is your greatest concern or need?

_____

_____

_____

Symptoms (Check all that apply):

☐ **Anxiety**	☐ **Sexual Problems**	☐ **Relationship Problems**	☐ **Parent/Child Problems**
Panic Attacks	☐ **Thoughts of Suicide**	☐ **Impulsive Behavior**	☐ **Personality Problems**
☐ **Depression**	☐ **Work Problems**	☐ **Financial Problems**	☐ **Childhood Trauma**
☐ **Low Self-Esteem**	☐ **Significant Life Changes**	☐ **Easily Annoyed/Irritated**	☐ **Excessive Stress**
☐ **Loss/Grief**	☐ **Addictions**	☐ **Abusive Relationship**	☐ **Difficulty Concentrating**

If you have been having thoughts of suicide, when was the most recent incident: _____

Have you been treated by, consulted with, or received counseling/therapy from a mental health professional in the past? Yes ☐ No ☐

Are you currently under the care of a mental health professional? Yes ☐ No ☐

Health Information

Please list any previous therapy or treatment you have received from mental health professionals:

Date(s)	**Name of Therapist/ Place of Therapy**	**Nature of Problem/ Reason for Seeking Therapy**	**Result of Treatment**

Please list any medications that you are currently taking:

Name	**Dosage**	**Results**

Family Information

What is your marital status: Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

If applicable, what is your spouse's/partner's name: _____

Please list your children's names, ages and sexes:

_____

_____

_____

Education and Employment Information

Please check all that apply to you: High School Graduate ☐ Some College Experience ☐ College Graduate ☐

Trade/Business School Experience ☐ Graduate School ☐

Who is your present/most recent employer and your position:

_____

_____

Length of Employment: _____

Acknowledgment and Consent

My signature below acknowledges that I have been offered a copy of both the General Informed Consent and Policies Form, as well as, the Notice of Privacy Practices Form.

_____	_____	_____
Printed Name of Client	Signature of Client	Date
_____	_____	_____
Printed Name of Parent/Guardian (If client is under 18)	Signature of Parent/Guardian (If client is under 18)	Date
_____	_____	_____
Printed Name of Parent/Guardian (If client is under 18)	Signature of Parent/Guardian (If client is under 18)	Date
_____	_____	_____
Printed Name of Therapist	Signature of Therapist	Date