**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Email: Kellee@tendingrelationships.com
Website: www.tendingrelationships.com

# Intake Questionnaire and Registration Form for Individual Clients

The intake questionnaire is intended to help me understand the broader context of your life so I can support you more effectively. Please complete it and mail it to the address shown above at least 4 business days prior to your first appointment (not before your initial consultation).

---

**Contact Info**

Name: D.O.B:

Address:

Primary Phone: Initial if voice message is OK? Initial if text message is OK?

Second Phone: Initial if voice message is OK? Initial if text message is OK?

Email: Initial if Email is OK?

Emergency Contact –
Name/Relationship: Phone Number:

Primary Care Doctor: Phone Number:

Other Medical Provider(s): Phone Number:

**Personal Info**

Culture/Race: Religion:

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

# Intake Questionnaire and Registration Form for Individual Clients

Gender: Sexual Preference:
Marital Status: Partner's Name:

Employment (current and/or important past):

Education (degrees and/or present studies?):

**History of Present Problem**
Describe why you've come to counseling at this time (include any particular problems, when they started, and when/how often they occur)?

How does this problem affect your life?

What things have you tried to solve the problem?

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

# Intake Questionnaire and Registration Form for Individual Clients

Has anything been helpful?

Presence and severity of current symptoms/behaviors:
**Please write "O" if you do not experience this, "1" if you experience it once a week or less, "2" if you experience it more than once a week but less that daily, and "3" if you experience it daily.**

| | |
|---|---|
| Sadness: | Low Motivation: |
| Anxiety: | Worrying: |
| Fear: | Hyperactivity: |
| Anger: | Rage: |
| Unwanted thoughts: | Thoughts that race: |
| Weight gain or loss: | Eating/appetite difficulties: |
| Poor Memory Function: | Challenges in concentrating: |
| Sleeping too much or too little: | Panic: |
| Other (please state): | |

Overall, please rate the severity of the symptoms you are experiencing? (circle a number)
1----------2----------3----------4----------5----------6----------7----------8----------9----------10
Low Severe

What else should I know about the problem(s)?

**Psychiatric History**
If you have had previous therapy or psychiatric care please indicate when, for how long and with whom?

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

## Intake Questionnaire and Registration Form for Individual Clients

Have you ever been hospitalized for psychiatric reasons? If so, when and why (including symptoms and diagnosis)?

Please describe past treatments that have been helpful.

**Risk Assessment:**
Have you ever thought about, or attempted to kill or harm yourself? (please describe, e.g. when and how often?)

Have you ever threatened or taken actions to harm another? Explain:

Are you having any of these thoughts/feelings/impulses currently? Describe what you are experiencing?

**Trauma History**
Please describe any life-threatening incidents from your past, or ones that seemed life-threatening at the time?

Has someone you are close to ever been seriously hurt or killed? Please describe.

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

## Intake Questionnaire and Registration Form for Individual Clients

Please briefly describe any violent or traumatic incidents you have witnessed.

If you have ever been harmed physically or sexually please describe.

Do you have flashbacks or re-experience any of these traumatic events or have any disturbing sudden reactions? Please describe.

**Family Psychiatric History**
Please describe the mental health challenges (symptoms and diagnosis) of your other family members? What are/were their symptoms/diagnoses?

Did they/Have they received treatment?

**Medical Conditions and History**
Please describe any current significant health problems?

List all current medications (including psychiatric medications):

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

## Intake Questionnaire and Registration Form for Individual Clients

Please list any past significant health problems:

Any other health information that I should know?

**Substance Use**
For the following substances, please note the type, amount and frequency of your use:

Caffeine (i.e. coffee, tea, soda, energy drinks):
Cigarettes or chewing tobacco:
Alcohol:
Drugs:
Describe any recent changes in your substance use?

Have you ever been treated for substance abuse and/or regularly attended AA/NA?

**Family History -**About your childhood/developmental history:

Pregnancy and Delivery (re: your birth) – Describe any complications:

Developmental Delays – Were you delayed in significant milestones such as walking or talking, etc.?

Accidents or illnesses – Please describe any serious accidents and/or significant childhood illnesses or hospitalizations?

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

## Intake Questionnaire and Registration Form for Individual Clients

Separations – Please describe significant separations from your parents:

Other Significant Events – Please describe other traumas, abuses, or significant occurrences (e.g. divorce, moves, death of loved one):

Please describe your parents approach to raising, relating and disciplining you:

Please describe how they related to each other:

Describe any significant issues with other members of your family that may have impacted your development:

How are your current relationships with your family of origin?

**Current Relationships**
Please list the names and ages of your current family members:

Are you concerned about drug or alcohol use by anyone in your family?

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

# Intake Questionnaire and Registration Form for Individual Clients

**Family and Community Resources:**
What family members currently provide support (emotional, financial, etc.) to you when needed?

Who else is supportive to you?

Describe your community or church activities/involvement?

**Relationships:**
Are relationships a challenge for you? Please explain why or why not.

Please describe concerns you have about your relationships at this time

**More about You**
Cultural Issues: What is important for me to know about your cultural heritage and ethnic background?

What cultural holidays or traditions do you maintain?

**Legal History:**
Please describe any history of arrests/convictions:

Are you currently on probation?

Describe any lawsuits you are involved in:

**Tending Relationships P.L.L.C.**
Kellee Gibbons, MA, LMHC
793 Ericksen Ave. NE, # 121, Bainbridge Isl., WA 98110
206-842-5734 Kellee@tendingrelationships.com

## Intake Questionnaire and Registration Form for Individual Clients

**Strengths, interests, etc.:**
Describe some of your strengths?

Describe what you are curious about and what motivates you?

What do you do to relax and have fun?

What else should I know about you (you may write on the back if you have more to say?

This information is, to the best of my knowledge, true and I understand that it may be used in my treatment.

Signed _____ This Date: _____

Name: _____ Date of Birth: _____