Marina Bommarito, MA, LPCC, BCN
586-419-8693
BommaritoCounseling@gmail.com

Client Intake Information (Adult)

Date: _____

Demographic Information

Client Name:_____
First Middle Last

Emergency Contact (name and phone number): _____

Client's Birth date: _____ Age: _____ Gender: _____

Street Address:
_____

_____

Phone: _____ Email: _____

How do you prefer to be contacted? _____

Ethnic Background: ___ African American ___ Asian/ Pacific Islander ___Caucasian/White
___ Hispanic/ Latino(a) ___ Native American ___ Other

Personal Information

Briefly describe the presenting problem (Precipitating factors leading to seeking counseling):
_____
_____

What strategies have been attempted to address this problem? How much did those strategies help?
_____
_____

When is the presenting problem less likely to occur? What typically helps you feel better?

_____

_____

What are your strengths and interests?

_____

_____

Are there any medical/mental health diagnoses? (if yes, please name diagnosis and age of diagnosis):_____

Occupation: _____

If you are a student, what school are you attending?: _____

Health:

Last Doctor's visit_____ Physician's name:_____ Phone _____
(Date)

Please list any Medications and Reasons for Medications:

_____

_____

Briefly describe any medical health, problems, and/or any hospitalizations:

_____

_____

Is there a significant family medical or mental health history:

_____

_____

Allergies:

_____

Please describe any trouble you have sleeping.

_____

_____

Are you currently or have you in the past participated in therapy, alcohol or drug treatment, or been under psychiatric care? If yes, please provide a brief explanation and diagnosis if one was provided.

_____

_____

Describe if any, current and past use of alcohol, caffeine and/or smoking

_____

_____

Household Status:

Marital Status: ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed

What is your current living situation? (e.g. living alone, with parents, partner, etc.)

_____

How would you describe your relationship with your family members: _____

_____

Names/Ages of siblings:_____

I _____ do sign that the information given today is true and accurate information.

_____ _____

Client's Signature Therapist's Signature

_____ _____

Client's Printed Name Date

14062 Denver West Parkway Suite 140, Golden, CO 80401
586-419-8693
BommaritoCounseling@gmail.com
LPCC.0018066