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Confidential Client Intake Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
Leave message? []Yes []No Leave message? []Yes []No

Work Phone: _____ Email: _____
Leave message? []Yes []No Contact by email? []Yes []No

Occupation: _____ Best time/day to contact you: _____

Birth date: _____ Age: _____ Marital Status: [] Single [] Married [] Divorced [] Separated

Education Level: [] 8th Grade or Below [] High School [] Some College [] Associates [] Bachelors [] Masters [] Doctorate

Have you been in counseling/therapy before? []Yes []No If yes, when: _____ Did it help? []Yes [] Some []No

Reason for therapy? _____

Have you or a family member ever attempted suicide? _____

Please list all medications you take: _____

Physician's Name: _____ Phone number: _____

Psychiatrist's Name: _____ Phone number: _____

Do you have any physical disabilities or chronic illnesses? (please list): _____

Please circle any of the following that are currently troubling you:

- Alcohol/Drug use Eating Problems Physical Abuse Communication with Partner Motivation
Self-Esteem Sexuality Verbal Abuse Sexual Harassment School/Educational
Assertiveness Suicidal Thoughts Sexual Abuse Stress Dating
Addiction Alcohol or Drug Issues Marriage/Spouse/Partner Spiritual/Religious Career
Appearance/Weight Depression/Sadness Loneliness Work Stress Time Management
Expressing Feelings Anxiety/Panic Perfectionist Money/Financial Issues Hopelessness
Grief/Loss Worry/Fear Shyness Childhood Issues Divorce/Break up
Meeting People/Friends Anger/Rage Sleep PTSD Parenting
Guilt Helplessness GLBT issues Boredom Traumatic Event
Homesickness Stalking Trust Relationship issues Family

Briefly describe your reason for seeking counseling: _____

How will you know counseling is working: _____

1) Emergency Contact: _____ Relationship: _____ Phone: _____

2) Emergency Contact: _____ Relationship: _____ Phone: _____