

**Lynn Powell, LMHC Counseling**  
4540 Southside Boulevard Suite 604 Jacksonville, FL 32216  
(904) 502-4813

**COUNSELING INTAKE FORM**

**Demographic Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Status (circle): FT, PT, PRN, student, returning to work, self-employed, unemployed

Highest Level of Education: \_\_\_\_\_

You like to be addressed using the pronouns: \_\_\_\_\_

Military member (circle): Yes No Branch: \_\_\_\_\_ Years Active: \_\_\_\_\_

Current Status (circle): Active Reserve Retired Other: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you find out about Lynn Powell Counseling? \_\_\_\_\_

Have you had counseling before? Yes No If yes, who did you see, and when: \_\_\_\_\_

Have you ever been in a psychiatric hospital? Yes No If yes, when? \_\_\_\_\_

Have you ever been to a substance abuse rehab program? Yes No If yes, when? \_\_\_\_\_

Are there any health problems? Yes No If yes, please list: \_\_\_\_\_

Do you have any form of disability? Yes No If yes, explain: \_\_\_\_\_

List any medications that you are currently taking and dose: \_\_\_\_\_

\_\_\_\_\_

Is there any history of mental health or substance abuse issues in your family? Yes No

If yes, who and what type of issues: \_\_\_\_\_

\_\_\_\_\_

What issue brings you in today? \_\_\_\_\_

\_\_\_\_\_

When did this issue begin? Please describe events occurring at the time. \_\_\_\_\_

\_\_\_\_\_

Current status (circle): Single Married(since \_\_\_\_\_) Living with someone (since \_\_\_\_\_)

Separated(since \_\_\_\_\_) Divorced(since \_\_\_\_\_) Widowed(since \_\_\_\_\_)

**Important Previous Relationships:**

Name: \_\_\_\_\_ Time together: \_\_\_\_\_ Married/Civil Union: Yes No

Why did relationship end? \_\_\_\_\_

Name: \_\_\_\_\_ Time together: \_\_\_\_\_ Married/Civil Union: Yes No

Why did relationship end? \_\_\_\_\_

**Please circle any issue you would like to discuss:**

Communication    Anger    Depression    Obesity/Weight    Substance Abuse    Traumatic Event    Career Issues  
Family of Origin    Relationship Conflict    Financial    Parenting    Medical    Infidelity  
Sexual Identity    Gender Identity    Codependency    Addiction    Childhood Abuse    Grief Issues  
Other: \_\_\_\_\_

**Children/Step Children**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Lives with you? Yes No Child/Stepchild  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Lives with you? Yes No Child/Stepchild  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Lives with you? Yes No Child/Stepchild  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Lives with you? Yes No Child/Stepchild

Is there any current or pending or divorce/custody disputes civil or criminal litigation ? Yes No

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Name(print): \_\_\_\_\_ Date: \_\_\_\_\_