Monica Kieffer, DO, LMFT

Counseling Intake Form

Name____ Age______ Gender: F M

Address____

City____________________________________ State____________ Zip___________________________

Phone: Home____________________ Work______________________ Cell_________________________

Marital Status: ____Single ____Married ____Widowed____ Divorced _____Separated_____ Other

Emergency Contact_____________________________ Relationship__________ Phone _______________

Mental health history (please describe):______________________________________

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Health problems____

Current medications or herbs for anxiety, depression, insomnia, and/or a mental health diagnosis: _____

____

Other medications: ____

Family Doctor: ______________________________________ Phone: _______________________________

Current counseling concerns: ____

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Have you ever received prior counseling or are you receiving counseling elsewhere now? Yes No

If yes, describe: ____

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What is your perception of how you are doing now? ____

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