

OFFICE USE ONLY:

CONFIDENTIAL CLIENT INTAKE

Please complete clearly & accurately

Jenny Stepp, M.A., L.C.P.C.
Licensed Clinical Professional Counselor
9402 W. Lake Mead Blvd., Las Vegas, NV 89134
702-336-7620
jenny@lvcounselor.com

Date _____
Client's First Name _____
Last Name _____ MI _____
Parent/Guardian's Name (if client is a minor) _____
Guardian Phone _____
Birth date ____ / ____ / ____ Age _____
Gender Identity __Woman __Man __Trans (MTF) __Trans (FTM) __Genderqueer __Other __Decline
Address _____
City _____ State _____ Zip _____
Client Cell Phone _____
Ok to leave voicemail? __Yes __No
Ok to send text message appointment reminder? __Yes __No
Client Home Phone _____
Ok to leave voicemail? __Yes __No
Email _____
Ok to send email to this address? __Yes __No

Family Background

Marital Status __Single __Married __Divorced __Separated __Widowed
__Living Together __Legally Separated __Registered Domestic Partner __Other
Name of Partner _____
Number of children and ages _____

Emergency Information

In case of emergency, contact:

Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Phone _____

Employment & Education Information

Current Occupation _____

Employer _____

Highest Degree Completed _____

Current Grade & School (for minor clients) _____

Referral Source

How did you hear about me?

LVCounselor.com website

Psychology Today website

Google search

Referred by friend or family member

Referred by physician (specify) _____

Other (please specify) _____

Please describe what brings you into counseling today: _____

Previous Counseling & Treatment

Have you been in counseling before? Yes No

If yes, name of counselor _____

Reason _____

Approximate dates of treatment _____

Have you been diagnosed with a mental health condition in the past? Yes No

If yes, please list diagnosis _____

Approximate date of diagnosis _____

Have you been hospitalized before for mental health treatment? Yes No

If yes, location and date _____

Are you having thoughts about suicide? Yes No

Are you having thoughts about harming someone else? Yes No

Are you currently on medication? Yes No

If yes, name of medication _____

Reason _____

Previous medications _____