

## LeBauer Counseling

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### Client Intake Form

Today's Date: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Relationship Status:  Single  Married  Domestic Partner  Significant Other

Widowed  Separated  Divorced Other: \_\_\_\_\_

Partner's Name (if applicable): \_\_\_\_\_

How did you hear about LeBauer Counseling?

Word of Mouth  Professional Referral  LeBauerCounseling.com

TherapyHelp.com  Other: \_\_\_\_\_

Referral Information:

I often thank referrals for sending you my way. Whom may I thank for referring you?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No



Do you have any children:       Yes     No

If yes, please indicate their names, ages, and your relationship to them, including biological, step-, foster, adoption, and legal relationships with other parents.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please describe the main concern that has brought you to see me.

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For how long have you been experiencing this concern? \_\_\_\_\_

<b>Symptoms:</b>			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Compulsive behaviors	<input type="checkbox"/> Confusion	<input type="checkbox"/> Depression
<input type="checkbox"/> Excessive use of alcohol or drugs	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Impulses to hurt self or others
<input type="checkbox"/> Weight gain or loss	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Lack of energy	<input type="checkbox"/> Loss of interest
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Self-critical
<input type="checkbox"/> Seizures	<input type="checkbox"/> Anger	<input type="checkbox"/> Sleep difficulties	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Suspiciousness	<input type="checkbox"/> Disorganized Thoughts	<input type="checkbox"/> Irritability	<input type="checkbox"/> Others:
<input type="checkbox"/> Moments of not knowing where you are or whom you are with.	<input type="checkbox"/> Hallucinations, seeing or hearing things.	<input type="checkbox"/> Obsessive worries or repeated thoughts	_____
			_____

Please list other conditions, mental health concerns and medical diagnoses:

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Please describe any recent losses or significant changes in your life:

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Please describe any family history of mental illness and/or substance abuse:

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Please indicate prescription medications you have taken for emotional, mental or psychiatric concerns:

Medication	For What?	Results?	When/How long?	Prescribing Doctor?

How many hours of sleep do you get per night? \_\_\_\_\_

Please describe any problems sleeping: \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

Have you noticed any major weight changes in the last 6 months?  Yes  No

When was your last annual physical? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Phone Number: \_\_\_\_\_

Have you had any suicidal thoughts or attempted suicide?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you received counseling, psychotherapy, or psychiatric treatment before?  Yes  No

If yes, for what concerns and with what results? \_\_\_\_\_

Have you ever been hospitalized for a psychiatric concern?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you used aggression or violence to influence others or to get your way?  Yes  No

Have you ever been incarcerated or imprisoned?  Yes  No

Do you have any pending lawsuits or are you planning on filing suit against anyone? Are there any lawsuits filed against you? Please describe below:  Yes  No

Have you been the victim of violence or abuse (including physical, sexual, verbal and emotional)?  Yes  No

Please explain: \_\_\_\_\_

Have you witnessed domestic or street violence?  Yes  No

As a child did you experience the death of a parent, friend, or sibling?  Yes  No

Have you ever felt the need to cut down on your drinking?

Yes     No

How much beer, wine, or liquor do you consume each week, on average? \_\_\_\_\_

Which recreational drugs have you used in the last 10 years? \_\_\_\_\_

Which drugs do you continue to use and with what frequency? \_\_\_\_\_

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Please write three goals for our work together in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

About how long do you expect to engage in therapy to fully reach these goals?

As long as it takes

6-10 sessions

10-15 sessions

I'm not sure what to expect.

Other: \_\_\_\_\_

How would you describe your motivation to actively engage in the therapeutic work, including the essential work done at home between sessions?

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