Client Intake Questionnaire

Please fill in the information you feel important to you and bring it with you to your first session or email to info@lighthousecounseling.ie. Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____
Date: _____
Parent/Legal Guardian (if under 18):

_____
Address:

_____
Home Phone: ___ _____ May we leave a message? □ Yes □No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
DOB: _____ Gender: _____
Referred By (if any):

_____

History

Main reason for seeking therapy

_____
_____

Are you currently working with any other physical or mental health services? □ Yes □ No. If yes, please list:

_____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

_____
_____

Are you currently taking any prescription medication? □ Yes □ No. If yes, please list:

_____
_____

Any other information that feels important to best serve you

_____
_____
_____