Lisa Cree Counseling, LLC

Client Intake Information

Please complete this form as accurately as possible in order to identify the services that will best meet your needs.

Today's Date: _____

Last Name: _____ First Name: _____

Nickname/preferred name: _____

Gender Assigned at Birth: _____ Preferred Pronouns: _____

Date of Birth: _____ Age: _____

Race: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Marital Status: _____ Spouse/Partner's Name: _____

Is it okay to leave phone messages?

☐ YES ☐ NO

Is it okay to send text messages?

☐ YES ☐ NO

Insurance Information

Name of Insurance Company: _____

Insurance Contact Number: _____

Name of Policy Holder: _____

Member ID #: _____ Group Policy #: _____

Date of Birth of Policy Holder: _____

Address of Policy Holder: _____

Relationship to Policy Holder: _____

100 SAW MILL RD., SUITE 3200
LAFAYETTE, IN 47905
765-404-1109
765-374-4164 FAX
EMAIL: THERAPY@LISACREECOUNSELING.COM

Counseling History and Current Concerns

List any previous counseling experiences.

Date	Provider	Reason

How would you describe your health? _____

Please list any medical concerns you are having:

_____

_____

_____

Current Medications	Reason for Medication

*Please bring a list of any additional medications to your initial appointment.

Primary Care Doctor: _____ Phone: _____

Any specialists seen: _____

Please describe the reasons you are seeking counseling at this time:

_____

_____

_____

_____

_____

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Please check any of the following which apply to you:

- ☐ Depression
- ☐ Drug/Alcohol Problems
- ☐ Grief
- ☐ Anorexia/Bulimia/Disordered Eating
- ☐ Family Problems
- ☐ Abortion/Miscarriage
- ☐ Stepfamily Issues
- ☐ Adoption Issues
- ☐ Physical/Mental/Sexual Abuse
- ☐ Stress
- ☐ Legal Problems
- ☐ Self-esteem Issues
- ☐ Divorce
- ☐ Anger Issues
- ☐ Anxiety
- ☐ LGBTQ+ Issues
- ☐ Problems at Work/School
- ☐ Marriage/Relationship Issues
- ☐ Financial Problems
- ☐ Gambling
- ☐ Mood Swings
- ☐ Behavioral Problems
- ☐ Parenting Concerns
- ☐ Trauma
- ☐ Self-Harm/Suicidal/Homicidal Thoughts

Are you having current suicidal or homicidal thoughts?

☐ YES ☐ NO

Do you have an active plan or intent to harm yourself or anyone else?

☐ YES ☐ NO

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