**Sam Poyta Counseling, PLLC**

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**Intake Form – Thank you for taking the time to provide this information.**

(Please share as you feel comfortable)

Full Name:

Date of Birth:

Gender Identity:

Pronouns:

Race/Ethnic Origin:

Religious Identity:

Email:

Cell Number:

Is it okay to leave you a voicemail on your cell? Y / N

Home address:

Health Insurance:

Employer/School:

How did you hear about me?

Emergency Contact:

**Personal Strengths**

What are some activities you enjoy doing?

Who are some supportive/helpful people in your life?

**Current Reason for Seeking Counseling**

What are the reasons for which you are seeking counseling?

Please list 3 treatment goals you would like to work toward in therapy:

**Previous Mental Health Counselors**

Name of Counselor (and clinic):

Dates of attendance and amount of time seen:

If any, what psychiatric conditions have you been diagnosed with?

What have you found most helpful in therapy?

What have you found least helpful in therapy?

Have you ever been hospitalized for psychiatric reasons? Y / N

If yes, please specify how often (include dates):

**Alcohol/ Drug Use and Treatment History**

Do you use: Cigarettes \_\_\_\_ Alcohol \_\_\_\_ Drugs \_\_\_\_

If yes, what kind? Specify amount and frequency per week:

Have you used substances in the past? Y / N

If yes, when, how often, and what type?

Have you received any previous treatment for substance use? Y / N

If yes, was your treatment:

Inpatient \_\_\_\_\_\_\_ Outpatient \_\_\_\_\_\_\_ Program Name:

**Family Information**

Current marital status: Married \_\_\_\_\_ Living with partner(s) \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ In the process of getting divorced \_\_\_\_\_

Do you have frequent arguments with your spouse/partner(s)? Y / N

If yes, what are the most common topics of arguments?

Has anyone in your family experienced difficulties with the following?

(Please list relationship to you)

Depression Y / N

Bipolar Disorder Y / N

Anxiety Y / N

Panic Attacks Y / N

Schizophrenia Y / N

Alcohol/Substance Use Y / N

Eating Disorders Y / N

Learning Disabilities Y / N

Suicide Attempts Y / N

Psychiatric Hospitalizations Y / N

**Trauma History**

Do you have a history of childhood neglect or abuse (physical, emotional, sexual)? Y / N

Have you or your family experienced any traumatic events (immigration, political violence, natural disaster, car accident)? Y / N

If yes, please share as you feel comfortable:

**Medical History**

Medication allergies or other allergies:

Current medications (include name, dosage, frequency, and reason for taking):

Primary Care Physician’s name, practice name, and contact information:

**Diet/Exercise and Pain Management**

Are you satisfied with your current diet? Y / N

If no, what dietary changes would be beneficial to you?

Do you exercise regularly? Y / N

If yes, what do you do for exercise?

Do you experience chronic physical pain? Y / N

If yes, what have you done for pain management?

**Diagnostic Checklist**

Please circle all items which you are currently or have experienced in the last three months

|  |  |  |  |
| --- | --- | --- | --- |
| Suicidal thoughts, wanting to hurt oneself |  | Nightmares |  |
| Wanting to hurt others |  | Reoccurring/intrusive thoughts |  |
| Has attempted suicide |  | Loss of sexual interest |  |
| Has threatened suicide |  | Need to use drugs/alcohol |  |
| Depressed |  | Overwhelming shame |  |
| Poor appetite or overeating |  | Overwhelming guilt |  |
| Low self-esteem |  | Feeling lonely |  |
| Feelings of hopelessness |  | Shaky hands |  |
| Difficulty sustaining attention on tasks or play activities |  | Mood swings |  |
| Feels hyperactive and restless |  | Loss of weight |  |
| Difficulty concentrating or making decisions; mind going blank |  | Unable to have fun |  |
| Feeling keyed up, restless, on edge |  | Muscle twitching |  |
| Easily fatigued, low energy |  | Can’t make decisions |  |
| Irritability, outbursts of anger, often loses temper |  | Feeling fearful and anxious |  |
| Panic attacks |  | Full of energy |  |
| Difficulty falling or staying asleep or restless sleep |  | Crying spells |  |
| Feeling depressed and/or anxious in response to an identifiable stressor |  | Quick tempered |  |
| Phobic avoidance associated with the specific object or situation |  | Impatient with people |  |
|  |  |  |  |

Other symptoms?

Is there anything else that you would like me to know?