Sara Muckler, MA, LCPC, LMHC
Dba Sara Muckler, MA PLLC
1205 Highway 2, Ste 301, Sandpoint, ID 83864 206-605-6329

INTAKE SUMMARY

Date: _____

Client Name: _____

Age: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Acceptable to contact you and leave a message on (circle):
Phone: Y / N Text: Y / N Mail: Y / N Email: Y / N

Occupation: _____

Current Employer: _____

Emergency contact: _____ phone: _____

Relationship to you: _____

MEDICAL AND HEALTH:

Do you have any chronic or current medical or physical condition? Y / N

If yes, please specify: _____

_____

_____

Are you currently taking any medications prescribed and over the counter? Y N

Medication	Purpose?	Duration?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently experiencing overwhelming sadness, grief, or depression? Y / N

If yes, for approximately how long? _____

Are you currently thinking of self-harm or suicide? Y / N

If yes, for approximately how long? _____

Have you had incidents of self-harm or attempted suicide in the past? Y / N

If yes, when? _____

Do you experience or have you experienced any auditory or visual hallucinations? Y /N

If yes, when and can you describe them? _____

_____

If yes, any hospitalizations? Y / N If yes, where and when? _____

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Is there a history of mental health or alcohol/substance abuse in your family history? Y / N

If yes, please indicate who and what (anxiety, depression, bipolar disorder, schizophrenia):

_____

_____

RELATIONSHIPS AND FAMILY:

Please check all that apply:

☐ Single ☐ Married: # years_____ ☐ Coupled not married: # years_____

☐ Separated ☐ Divorced: when (list all divorces)_____

☐ Widowed: when_____ length of relationship_____

Name of current partner/spouse: _____ Age: _____

Is your relationship open or polyamorous? Y / N

If yes, please include the names of additional partners.

Name of partner/spouse: _____ Age: _____

Name of partner/spouse: _____ Age: _____

Children:

Name	Age	Gender	Parent (other than you)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do your children live with you full time? Y / N If no, with whom do they live? _____

IDENTITY:

The following information is used so that I can provide care that is respectful of your identity and sensitive to the issues you face. **If you do not have an answer or are not comfortable answering at this time, feel free to leave any (or all) line(s) blank.**

How do you identify your:

Race: _____ Ethnicity:_____

Religion/denomination/spirituality: _____

Sexual Orientation: _____ Gender: _____

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ALCOHOL AND DRUG USE:

Do you smoke? Y / N Started at age: _____ Quantity and frequency: _____

Do you drink? Y / N Started at age: _____ Drinks per week: _____

Do you use other drugs (marijuana, cocaine, heroin, methamphetamines, etc.) Y / N

Which drug(s)? _____

Started at age: _____ Frequency and quantity: _____

Treatment (years and setting):_____

Any recent changes in smoking, alcohol, or drug use? Y / N

Have you seen a therapist before? Y / N

When and for what? _____

STRENGTHS AND RESILIENCY:

What are the current ways that you relax and rejuvenate?

What do you do to have fun?

What would you consider is one of your strengths or one thing you do well?

What would you like to accomplish out of your time in therapy?

I certify that the information listed above is true and accurate to the best of my knowledge.

Client Name/Date