DR. Joanne Halverson,, Doctorate in clinical Psychology
425 761 0028
THRIVE COUNSELOR SEATTLE

I N T A K E F O R M

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.
Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed
Please list any children/age: _____
Address: _____
(Street and Number)
_____
(City) (State) (Zip)
Home Phone: ( ) May we leave a message? □ Yes □ No
Cell/Other Phone: ( ) May we leave a message? □ Yes □ No
E-mail: _____ May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any): _____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes

Do you drink alcohol more than once a week? □ No □ Yes
How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
Are you currently taking any prescription, including psychiatric medication, medication?
If so, please list:
_____
_____
Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently:
_____
_____

What do you want to
heal/change?_____
_____
_____
_____