Michael Hollingsworth, LCPC, LLC
Scheduling Email:
michaelhollingsworthlcpc@gmail.com

106 W Main St, STE E
Middleton, ID 83644

Client Intake Information			
Client's Full Name:			
Name of Responsible Party (minors only):			
Today's Date:	Client's Age:	Client's DOB:	Client's Gender:

Contact Information		
Address:		
City:	State:	Zip Code:
Cell Phone Number (Preferred? Y/N)	Would you like to receive appointment reminders on your cell phone via text message? YES or NO	
Is it okay to leave voicemail messages on your cell phone number? YES or NO	Email:	

Emergency Contact Information		
Name of Emergency Contact:		Phone #:
Relationship to Client:	Address:	
City:	State:	Zip Code:

Medical Information		
Primary Care/Prescribing Physician (if applicable):	Known Allergies:	
Current Medications / Dosage / Approximate Month and Year Started:		Past psychiatric medications:

Referral Source

How did you hear about our clinic?

From another medical provider Internet Friend/Relative

Other (please describe): _____

Name of referral source (if another medical provider):	Address (if known):	
City:	State:	Zip Code:

Treatment History

Have you ever been in counseling? YES or NO	If yes, name of most recent clinic/provider:
Reason for seeking services at that time:	
Have you ever been hospitalized for mental health treatment? YES or NO	
If yes, please provide the dates and a brief description of each hospitalization:	

Reason For Seeking Services

Please provide a brief explanation regarding why you are seeking services at this time:

Have you experienced any recent major life transitions or events? If yes, please describe.

Are you currently involved in any legal proceedings? If yes, please describe.