APRICITY WELLNESS COUNSELING

915 Russell Avenue
Suite B
Gaithersburg, MD 20879

Roni K. White, MS, NCC, LGPC

(301) 281-6550 | roni@apricity.sprucecare.com

Helping people focus on the Light when the shadow feels overwhelming.

Client Intake Form

Today's Date _____

Personal Information

Name: First _____ Last: _____ MI _____

Nickname: _____ Birth Date: ___/____/_____

Gender: □ Female □ Male □ Transgender □ Non-binary □ Prefer to self-describe: _____

Sexual Orientation: _____ Relationship Status: _____

Military Service: □Yes □ No / Branch _____ Active: □ Yes □ No

Ethnicity: _____Religion/Spirituality: _____

Education Status: (Current or highest grade/degree completed) _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____ - _____ Cell Phone (____) _____ - _____

List each member of your household (name, age, and relationship to you):

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_____

_____

Counseling Information

Primary reason for counseling services (briefly describe):

_____

_____

_____

When did the reason indicated for seeking counseling begin?

□ within 30 days □ within 6-12 months □within 2 years □ during adolescence □during childhood

What areas of your life have been affected because of this problem?

_____

_____

What would you like to accomplish in our time together?

_____

Any current or past thoughts of suicide or self-harm? _____

Any thoughts of harming others or homicide? _____

Were you referred by? □ Medical Provider □Mental Health Professional □Spiritual Leader

□ Insurance Provider □ Psychology Today □Friend/Family □Other: _____

Have you previously received any type of mental health service? □ Yes □ No

If yes, please list previous counseling or psychiatric care you received below:

Counselor/ Date of Service/ Reason care discontinued_____

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_____

_____

_____

_____

Any previous hospitalizations or day treatment programs? _____

_____

Developmental History

Please list any major events or concerns about your (the client) developmental milestones (average, early, delayed, unknown):

Pregnancy and birth: _____

Infancy: _____

Childhood: _____

Adolescence: _____

"Adulting": _____

Adulthood: _____

Where were you born? _____ Where did you grow up? _____

Have you experienced any major losses, trauma, or traumatic experience? ☐ Yes ☐ No

Please list any family members and relationship to you with mental illness and/or substance abuse, if known:

_____

_____

_____

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Wellness Information

Date of last physical exam: _____ Date of last dental exam: _____

Date of last eye exam:_____ Date of last annual: _____

Any allergies? Please list: _____

_____

List any vitamin and vitamin supplements you take and how often:

_____

_____

List all current medications, including over the counter medications you take and how often:

_____

_____

_____

How would you characterize your overall health? _____

How well are you sleeping? □ Not sleeping □ Wake often □ Unrestful □ Restful □ Energizing

How many hours a day do you have screen time (all electronics)? ____

How many times per week do you generally exercise? _____ How long do you exercise? ____

What is your favorite beverage? _____ What is your daily caffeine intake? _____

How often do you drink alcoholic beverages? _____ Use tobacco/e-cigarette/vape: □Y □N

Use illegal drugs? □ Yes □ No Use marijuana □ Yes □ No Use medical marijuana □ Yes □ No

Drug: _____ Route/method: _____ Last Taken: _____

What do you enjoy doing in your free time/relaxing? _____