12 S Summit Avenue
Suite 100-A2
Gaithersburg, MD 20877

Roni K. White, MS, NCC, LCPC

(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: ____

Home Address: ____

City: _____________________________________ State: ____________ Zip: _____________

Home Phone (_____) _______ - __________ Cell Phone (____) ______ - ________

List each member of your household (name, age, and relationship to you): [on next page]

12 S Summit Avenue
Suite 100-A2
Gaithersburg, MD 20877

Roni K. White, MS, NCC, LCPC

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

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

____

____

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 _________________________

12 S Summit Avenue
Suite 100-A2
Gaithersburg, MD 20877

Roni K. White, MS, NCC, LCPC

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

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

____

____

____

____

Any previous hospitalizations or day treatment programs? ________________________

____

Developmental History

Please list any major events or concerns about your (the client) developmental milestones (i.e., average, early, delayed, unknown, or anything remarkable/life changing/concerning):

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:

____

____

____

12 S Summit Avenue
Suite 100-A2
Gaithersburg, MD 20877

Roni K. White, MS, NCC, LCPC

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

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

Wellness Information

Date of last physical exam: ____________________ Date of last dental exam: _______________

Date of last eye exam:___________________________ Date of last annual: ____________________

Have you had COVID-19? Yes No Have you had the COVID-19 vaccine? Yes No Date

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:

____

____

Emergency Contact (full name/phone/relationship): _______________________________________

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? ____