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Client Intake Information

Name _____ Date of Birth _____

Address _____

Phone Number: _____ e-mail _____

Single ___ Married ___ Partnered ___ Divorced ___ Widowed ___

Gender _____ Sexual Orientation _____ Pronoun _____

Religious affiliation _____

Children (names/ages) _____

Employment Information _____

Referred by: _____

Brief description of reason for seeking services

Check all that apply:

depression

anxiety

traumatic experience

relationship issues

family of origin issues

substance abuse (alcohol or drug)

physical or sexual abuse

medical concerns

loss and grief issues

other _____

Past mental health treatment _____

Current medications: _____

Please check all that apply:

	Present	Past
Increased sleeping	_____	_____
Decreased sleeping	_____	_____
Change in appetite	_____	_____
Increased crying	_____	_____
Mood changes	_____	_____
Panic attacks	_____	_____
Poor concentration	_____	_____
Memory concerns	_____	_____
Increased sadness	_____	_____
Lack of interest	_____	_____
Upset over past events	_____	_____
Difficulty controlling temper	_____	_____
Excessive worry	_____	_____
Change in sexual interest	_____	_____
Increased tiredness	_____	_____
Withdrawal from friends/family	_____	_____
Frequent arguments	_____	_____
Excessive fears	_____	_____
Thoughts of self harm	_____	_____
Thoughts of suicide	_____	_____
Attempts at suicide	_____	_____

Please describe most pressing issue or concern that you would like to address in treatment

How long have you been experiencing these concerns?

Family history of mental health issues, i.e. depression, anxiety, etc.

Please list any other information you feel would be beneficial for me to know:
