Intake Form

Frewin Hermer, LMFT
LMFT State of WA # LF60282308
(206)909-7510

This paperwork has been prepared to inform the reader of the qualifications clients can expect from Frewin Hermer Therapy. Please note you will receive an electronic copy to sign once services begin, this document is for review only. Please do not hesitate to contact us with any questions.

Please provide the following information and answer the questions below.
Please note the information you provide here is protected as confidential information.

Name:

_____ (Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____ (Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Please list any children/age: _____

Address: _____

City)____ (State)_____ (Zip)_____Home Phone:_____

(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.)?

☐ Yes ☐ No

Previous therapist/practitioner: _____

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Are you currently taking any prescription medication? ☐ Yes ☐ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

Please list and provide dates: _____

_____

General Health and Mental Health Information

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise per week? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

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7. Are you currently experiencing any chronic pain? [] Yes [] No

If yes, please describe _____

8. Do you drink alcohol more than once a week? [] Yes [] No

9. How often do you engage recreational drug use? (please cirlce)

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? [] Yes [] No

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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

_____

_____

Family Mental Health History

In the section below identify if there is a family history of any of the following, please indicate the family member's relationship to you, e.g. father - domestic violence.

Alcohol/Substance Abuse, Anxiety, Depression, Domestic Violence, Eating Disorders, Obesity, Obsessive Compulsive Behavior, Schizophrenia, Suicide Attempts

Family Member:	Mental Health History:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Additional Information

1. Are you currently employed? [] Yes [] No

If yes, what is your current employment situation:

_____

2. Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

Insurance Information

Insurance Company: _____

Policy Number: _____

Group Number: _____

Insurance Phone #: _____

Insured's name: _____

Birth Date: _____ /_____ /_____

Address (if different from Client): _____

(City) ____ (State) _____ (Zip) _____

Employer: _____