MAP YOUR CARE:
ILLNESS & GRIEF
COUNSELING, LLC

Bonnie Herrmann, LCSW, ACHP-SW
(720) 414-0320 | bonnie@mapyourcarecounseling.com

CLIENT INTAKE

Client's Name:

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

What is your gender identity? _____

What is your sexual orientation? _____

What is your race/ethnicity? _____

How may I contact you?

#1 (preferred): _____ ◯ cell ◯ home ◯ voicemail ok?

#2 (secondary): _____ ◯ cell ◯ home ◯ voicemail ok?

Email: _____

Are you interested in receiving appointment reminders?

◯ text ◯ voicemail ◯ email

Emergency Contact Information

Name: _____ Relationship to Client: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Primary Phone #: _____ Alternate #: _____

How did you hear about Map Your Care: Illness & Grief Counseling? (former client, therapist, google search, Psychology Today, website): _____

If a person directly referred you to MYC, what is their name? _____

May I contact them to extend my thanks? ◯ yes ◯ no

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What is your relationship status? ◯ Married ◯ Divorced ◯ Common Law
◯ Living with a partner/partnered ◯ Single/Never Married
◯ In a relationship/Not living together ◯ Grieving the loss of a partner
◯ Widowed Partner's Name (if applicable): _____

What is your highest education level? ◯ Less than high school diploma
◯ High school graduate ◯ Some college/associate degree
◯ Bachelor's degree ◯ Post graduate degree

Are you currently working? ◯ Yes What do you do? _____
◯ No When did you last work? _____

Have you or your spouse (if applicable) served in the U.S. Armed Forces, military reserves, or National Guard? ◯ Yes, myself Branch/Dates: _____
◯ Yes, my spouse Branch/Dates: _____ ◯ Neither

Support System

Who are the most important people in your life? (*Consider listing a partner, children, close friends, siblings, etc.)* _____

How satisfied are you right now with your support system? ◯ Very satisfied
◯ Somewhat satisfied ◯ Not at all satisfied

How do you reduce your stress? _____

What are some of your strengths? _____

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What brings you to counseling? *Check all that apply*.

- ◯ I was recently diagnosed with a new life-changing illness
- ◯ I'm looking for strategies and support in managing a chronic illness
- ◯ I have an advanced or terminal illness and am looking for support
- ◯ I'm considering comfort care (i.e. palliative or hospice care) for myself or a loved one
- ◯ I want to discuss legacy options as a comfort to my loved ones after I die
- ◯ I'm grieving the death of a loved one
- ◯ I'm a caregiver for a loved one *(providing physical, emotional, logistical and/or financial support to someone with health needs)*
- ◯ I'm a caregiver for someone with dementia and am looking for support
- ◯ I'm looking to update or complete my healthcare directives (i.e. living will, etc)
- ◯ I want help in talking about my healthcare wishes and what's important to me with my loves ones/my doctor
- ◯ I'm interested in discussing options like Medical Aid in Dying or Voluntarily Stopping Eating and Drinking (VSED)
- ◯ Other (please describe): _____

_____

What do you hope to achieve from counseling? _____

_____

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Clinical History

Have you ever received counseling before, for any of the previous concerns or for different concerns? ◯ yes ◯ no If yes, please describe: _____

_____

Are you currently being prescribed any psychiatric medications? ◯ yes ◯ no
If yes, please specify: _____

Have you taken any psychiatric medications in the past? ◯ yes ◯ no
If yes, please specify: _____

Have you ever attempted suicide/intentionally harmed yourself? ◯ yes ◯ no
If yes, how long ago? _____ Please briefly describe: _____

_____

Do you or a loved one have concerns about *your* use of alcohol, tobacco, or drugs?
◯ yes ◯ no ◯ I don't use any of the above substances
If yes, please describe: _____

Do you have a history of trauma?

◯ sexual assault (childhood/adult)
◯ childhood physical abuse
◯ childhood emotional abuse/neglect
◯ other: _____
◯ domestic violence
◯ serious accident (ie car accident)
◯ medical trauma ie treatment against your wishes

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Current Symptoms/Concerns

Please indicate the severity of the symptoms/concerns you are experiencing.

Never = I have never experienced this
Past = I am not currently experiencing this, but have in the past
Some = This is sometimes a concern/This mildly impacts my day-to-day functioning
A lot = This very frequently/often impacts my day-to-day *and/or* I want to actively address this concern in counseling

	Never	Past	Some	A lot
Depressed mood	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐
Self harm	☐	☐	☐	☐
Anxiety/worry	☐	☐	☐	☐
Mood changes	☐	☐	☐	☐
Anger/irritability	☐	☐	☐	☐
Guilt/shame	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Grief	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐
Obsessive thoughts	☐	☐	☐	☐
Mobility changes	☐	☐	☐	☐

	Never	Past	Some	A lot
Appetite changes	☐	☐	☐	☐
Difficulty sleeping	☐	☐	☐	☐
Low energy/fatigue	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐
Loss of interest/numb	☐	☐	☐	☐
Pain	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Relationship difficulties	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐
Memory loss	☐	☐	☐	☐
Legal concerns	☐	☐	☐	☐

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Medical History

How would you describe your overall physical health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Who is your primary care physician? Name: _____

Phone: _____ Fax *(if available)*: _____

Do you see any specialty physicians? (Oncologist, cardiologist, neurologist, palliative care, etc) ◯ yes ◯ no If yes, please specify name and specialty: _____

_____

Do you have any current medical conditions, chronic illness or physical complaints? (i.e. diabetes, chronic pain, cancer, COPD, heart failure, multiple sclerosis, etc.)
If yes, please specify: _____

_____

Please list any *past* illnesses you feel are relevant for our work together (i.e. cancer, traumatic injury, stroke, etc.): _____

_____

Do you experience any symptoms on a regular or semi-regular basis that affect your day-to-day life? (i.e. pain, difficulty breathing, etc): _____

_____

Are you currently taking medications for any of the above medical conditions? If yes, please specify: _____

_____

_____