Maria Klette-Ketchum
L.C.S.W., A.C.S.W., M.S.W., B.C.D., C.C.C.J.S.-M.A.C., S.A.P.

NAME: ______________________________________ **DATE:**________________________

1. Why are you seeking counseling?
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2. What are your goals or what would you like to achieve during these sessions?
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3. Are you currently suicidal or have you had any history of suicidal attempts?
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4. Would you like family members or significant others involved in your treatment?
If yes, then who? ____
If no, why not? ____

5. Have you had counseling previously? Yes___________ No_________________
If yes, with whom and when?
____
____

6. What medications do you currently take?
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7. Do you have any current or past significant medical problems, including surgery?
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8. Please list any allergies you may have. ____

9. What do you think your strengths and your limitations are?
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