

**Cynthia Benedict Goering MA, LMHCA**

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WA State Mental Health Counselor Associate License: MC60140954

**Intake Form**

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Sex (M /F): \_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

At which phone number may I contact you? \_\_\_\_\_

May I contact you via email and / or text message for scheduling purposes? \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/Studying: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

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Briefly tell me about the concerns that have brought you to counseling.

How would you like your life to be different as a result of counseling?

Are you currently under medical care? Yes / No

If yes, then please explain/describe.

Name and Phone Number of Primary Care Physician:

Please list prescribed and over-the-counter medications (including naturopathic and homeopathic)?

Please list any psychiatric/mental health medications you have taken.

