LIBBY HOWELL, ED.D
Licensed Psychologist

CLIENT NAME:_____ **DATE OF INTAKE**:_____

Describe the problem that brought you in today:

_____

_____

_____

_____

_____

Please check all the symptoms that apply:

☐	Depression	☐	Perfectionism	☐	Problems with anger	☐	Addictive behaviors
☐	Extreme sadness	☐	Trouble performing your job	☐	Change in eating habits	☐	Strange thoughts
☐	Feeling hopeless	☐	Feelings of extreme happiness	☐	Weight changes	☐	Feeling fearful
☐	Lack of enjoyment of usual activities	☐	Problems getting along with friends or family	☐	Thoughts of hurting or killing others	☐	Change in sexual interest or function
☐	Memory problems	☐	Thoughts of killing yourself	☐	Change in sleeping habits	☐	Paranoia
☐	Trouble concentrating	☐	Feeling nervous	☐	Easily irritated	☐	Irritability
☐	Lack of energy	☐	Obsessions or compulsions	☐	Feeling stressed		
☐	Feeling guilty	☐	Sudden feelings of panic	☐	Acting violently		

Have you ever been in counseling before? Yes_____ No_____
If so, please describe it below, staring with the most recent time first.

	Dates of Counseling	**Name of Therapist**	**Explain What Happened**
1.			
2.			
3.			
4.			