New Client Intake Form

Please download, print, fill out, and bring this form with you to your initial consultation. We will review this form and the information you have provided at your first visit, as well as answer any additional questions you may have.

The information requested in this form will be kept confidential.

GENERAL INFORMATION:

Last Name:_____ First Name: _____ Middle Initial: _____

Birth Date: ____/____/_____ Age: ___ Gender: □ Male □ Female □ Other Social Security #_____-____-_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Employer: _____ Profession/Vocation: _____

Religious Denomination/Spiritual preference: _____

Home Phone: _____ May I leave a message? □ Yes □ No

Cell/Other Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication. To authorize email communication, please complete the "Consent to Correspond Electronically" Form.

Emergency Contact:_____ Telephone: _____

Relationship to you: _____

Marital Status: □ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Referred by: _____

May we thank this person? □ Yes □ No

If so, please give contact information: _____

INSURANCE INFORMATION (if applicable):

Are you using insurance benefits? □ Y □ N

Are you: □ Primary Policyholder □ Dependent Relationship to Policyholder: _____

Insurance Company Name: _____

Street Address: _____ City: _____ State: ___ Zip:_____

Insurance ID #_____ Group #_____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____

Policyholder's SSN #: _____-____-_____ Policyholder's Employer: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

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:

_____

_____

_____

How would you rate your current sleeping habits? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____

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

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

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

Please list: _____

_____

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

Please list and provide dates: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? □ No □ Yes If yes, how often? _____

Do you currently use tobacco products? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? Bad 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 --- 10 Good

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with:	now	past	Difficulty with:	now	past	Difficulty with:	now	past
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following.
If yes, please indicate yourself and/or the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

History of:		Yourself / Family Member Relationship:
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Sexual Abuse	yes / no	
Suicide Attempts	yes / no	

COUNSELING CONCERNS:

What significant life changes or stressful events have you experienced recently?

Please describe the concerns that bring you to counseling at this time:

Please share what you hope to accomplish or gain through counseling: