Confidential New Client Intake Form

Intake Date

Personal Information

Name: _____ SS#:_____
Last First Middle

DOB: _____/_____/_____ Age: _____ Gender ◊ Female ◊ Male

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May we leave a message? ◊ yes ◊ no

Cell Phone: _____ May we leave a message? ◊ yes ◊ no

May I send statements and other correspondences to you at the address above? ◊ yes ◊ no

Email: _____ May we leave a message? ◊ yes ◊ no

Marital Status - *please check one*

◊ Student ◊ Single ◊ Domestic Partner ◊ Married ◊ Separated ◊ Divorced ◊ Widowed ◊ Religious Orders

Spouse/Partner/Parent Information

Name: _____ SS#:_____
Last First Middle

DOB: _____/_____/_____ Age: _____ Gender ◊ Female ◊ Male

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: _____ May we leave a message? ◊ yes ◊ no

In **case of an emergency,** whom should we notify besides your spouse/partner/parent?

_____

Name Relationship Phone

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Children and Others Living in the Home

Name and Relationship	Age	Gender	Grade	Living Arrangements

How did you hear about us?

◊ Family physician _____ ◊ Friend/Family ◊ Workshop/Class ◊ Google Search

◊ Psychology Today ◊ Phone Book ◊ Church bulletin ◊ Other:_____

Additional Information

Are you currently employed? ◊ yes ◊ no

If so, what do you do and where do you work? _____

How long have you done this line of work? _____

Are you happy with your work? ◊ Absolutely yes ◊ Somewhat ◊ Not really ◊ Not at all

If you are a student, where do you go to school and what grade are you in? What's your major?
_____

Are you or have you had any legal issues (probation, parole, jail, prison, DUI)? ◊ yes ◊ no

Please explain: _____

Any present or pending civil law suits? ◊ yes ◊ no

Do you practice any religion? ◊ yes ◊ no Religious Preference_____

Importance of religion to you/your family: ◊ Very important ◊ Somewhat important ◊ Not important

Were you adopted? ◊ yes ◊ no

If yes, do you have a relationship with your biological parents? ◊ yes ◊ no

Is there any other information you believe that I should know as your therapist?

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Why You're Here

What made you decide to pursue counseling? _____

_____

What do you hope to accomplish with this outpatient therapist? _____

_____

Previous Treatment

Have you received any mental health services in the past? Examples include: Outpatient Therapy, Medication Management, Case Management, Psychiatric, Mental Health Inpatient Hospitalization, Home-Based Therapy

Type of Treatment	Provider Name and Location	Currently in Treatment?	Approximate Dates of Service	Reason for Discontinuation	Helpfulness of Services*

*Helpfulness Please use the following scale to describe how helpful this was to you. 1 = Very helpful 2 = Somewhat helpful 3 = Unsure 4 = Not really helpful 5 = Not helpful at all

Medications

Please list the medications that you are currently on and any psychotropic medications you have been prescribed in the past. Please include any naturopathic supplements, such as St. John's Wort.

Medication	Current or Past	Dosage and Frequency	Prescribing Physician	Helpfulness*

Name and address of your current psychiatrist or treating professional:

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Family History

Please indicate in the section below if any family members have been treated for any of the following conditions. Identify their relationship to you (father, maternal grandmother, sibling, etc.).

		Relationship
◊ yes ◊ no	Depression	_____
◊ yes ◊ no	Anxiety	_____
◊ yes ◊ no	Bipolar Disorder	_____
◊ yes ◊ no	Suicide Attempt	_____
◊ yes ◊ no	Schizophrenia or Psychosis	_____
◊ yes ◊ no	Alcohol / Substance Abuse	_____
◊ yes ◊ no	Eating Disorder	_____
◊ yes ◊ no	Domestic Abuse (Victim/Perpetrator)	_____

Your Current Health

How is your current health condition? ◊ Excellent ◊ Good ◊ Fair ◊ Poor ◊ Terminally ill

Please list any health conditions for which you are receiving treatment: _____

_____

Do you smoke? ◊ yes ◊ no How many per day? _____
Do you drink alcohol? ◊ yes ◊ no Type and Frequency _____
Do you use recreational drugs? ◊ yes ◊ no Type and Frequency _____
Do you use sleeping aids? ◊ yes ◊ no Type and Frequency _____

Please check any present, past or impending issues that you may have. Please circle the ones of primary concern.

◊ Suicidal thoughts/attempts
◊ Cutting or other self harm
◊ Depression/hopelessness
◊ Anger issues
◊ Chronic pain or illness
◊ Sleep problems
◊ Communication problems
◊ Partner violence/abuse
◊ Sexual abuse/rape
◊ Drug and/or alcohol concerns
◊ Other addiction issues
◊ Marital affairs/infidelity/sexual addiction
◊ Sexual/intimacy concerns
◊ Job issues/unemployment/financial
◊ Remarriage adjustment
◊ Legal issues
◊ Divorce adjustment
◊ Major life changes
◊ Loss/grief
◊ Eating problems

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