New Client Intake Form

Welcome. Thank you for your time in completing this form. I look forward to meeting with you and to working together to reach your goals. This form is intended to help me become better acquainted with you and, in turn, serve you better. You may omit any item, but try to be as thorough as possible.

Please note: The information requested is confidential unless released with your written consent, except as otherwise required by law.

Client Name:_____Age:_____DOB:_____Date:_____

What are the major symptoms or difficulties that you want to address in our work together?_____
_____
_____

How long has the problem been present?_____

What solutions to the problem have you tried, and what were the results?_____
_____

Have there been any significant changes in your life recently? □ Yes □ No If yes, please describe:_____
_____
_____

Counseling History

Name(s) of any therapist you currently seeing?_____
_____

Are you **currently** under the care of a psychiatrist? □ Yes □ No
Psychiatrist:_____ Phone Number:_____
Address:_____City:_____ State:____ Zip:_____
Have you ever been given a mental health diagnosis? If so, please list:_____
_____
_____

Do you agree with the diagnosis? □ Yes □ No Please explain:_____
_____

Are you currently taking any current Mental Health Medications? □ Yes □ No

Medication and Dosage	Prescribed by	Prescribed for	Dates	Helpful?

Past Mental Health Treatment

Provider Name/Clinic/Hospital	Dates	Sought help for	Helpful?

Have you taken any Mental Health Medications in the past? □ Yes □ No If so, what medication(s)?_____
_____
_____

Have you had any negative experiences in therapy? □ Yes □ No _____
_____
_____

Individual Concerns (Please check all that apply):

__Abuse
__Learning Concerns
__Anger Management Concerns
__Anxiety, Nervousness
__Body Pains
__Bowel Changes/ or Distress
__Change in Appetite
__Change in Sleep Habits
__Compulsive Behavior
__Concentration Difficulties
__Conflict with Family
__Crying
__Decreased Interest in Activities
__Depression
__Difficulty Concentrating
__Difficulty Forming Lasting Relationships
__Difficulty Identifying, Feeling, and Expressing Emotions
__Difficulty with Transitions
__Difficulty Trusting Others
__Dizziness
__Distractibility
__Eating Concerns
__Enmeshment
__Excessive Self-Sacrificing
__Family Disconnection
__Family Conflicts
__Relationship Conflicts
__Fear
__Fear of Abandonment
__Fear of Disappointing Others
__Feeling Doomed
__Feeling Helpless
__Feeling That You are too Dependent on Others
__Feelings of Emptiness
__Feelings That Others Are Taking Advantage of You
__Flashbacks
__Grief and/or Loss
__Guilt/Shame
__Hallucinations
__Harassment
__Highly Sensitive Person
__Hopelessness
__Hurting Others
__Hurting Self
__Hyper-Critical of Self
__Hyper-Vigilance
__Idealizing and Then Devaluing People in Your Life
__Identity/Sense of Self Concerns
__Impulse Control Concerns
__Intrusive Thoughts
__Intense/Unstable Relationships
__Intolerance
__Intrusive Thoughts
__Irritability
__Isolation
__Judgment Errors
__Loneliness
__Loss of Direction in Life
__Loss of Pleasure
__Memory Impairment
__Midlife Crisis
__Mood Swings or Period of Intense
__Muscle Tightness
__Nightmares
__Obsessions
__Phobias
__Procrastination/Avoidance
__Racing Thoughts
__Recurring Thoughts
__Resentments
__Sadness
__Self-Mutilation/Self-Injury
__Shutting Down
__Stomach Pains/Distress
__Stress
__Suicidal Acts or Threats
__Suicidal Thoughts
__Thoughts are Disorganized
__Tiredness/Fatigue
__Try to Please Others
__Unable to Relax
__Unstable Sense of Self
__Weight Changes
__Withdrawal and Loss of Interest
__Other_____

General Health Information

Primary Care Physician/Clinic:_____Phone Number:_____
Address:_____City:_____ State:_____ Zip:_____
Most recent medical examination(s):_____

Who else do you see as a part of your regular health care routine? (Specialists/Doctors, Chiropractor, Acupuncturist, Physical Therapist etc.):_____
_____

Are you currently taking any <u>medications for medical conditions</u>? □ Yes □ No

Medication/Dosage	Prescribed by	Prescribed for	Dates	Helpful?

Please list any current vitamin, herbal, or homeopathic supplements that you use on a regular basis and who prescribed them for what condiditon(s)._____
_____

Please List any Current or Past Health Problems or Concerns:_____
_____

Have you had any hospitalizations/surgeries? □ Yes □ No List/Dates:_____
_____

How would you rate your current physical health? (Please circle)
Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current energy level? (Please circle):
Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleep patterns? (Please circle):
Poor Unsatisfactory Satisfactory Good Very Good
What sleep issues, if any, do you have? (*Choose all that apply)*
□ Difficulty falling asleep □ Difficulty getting up in the morning □ Difficulty staying asleep □ Oversleeps
How many hours of sleep do you get per night?_____Hours of uninterrupted sleep?_____

How would you rate your current eating habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very Good
How is your appetite?:_____ Weight gain or loss?:_____How much?:_____
Are you concerned about your eating? □ Yes □ No Are others concerned? □ Yes □ No Whom?_____

How would you rate your current exercise habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very Good
How much do you exercise a week?:_____
Are you concerned about your exercising? □ Yes □ No Are others concerned? □ Yes □ No Whom?_____

What are your current coping mechanisms/strategies?:_____
How do you currently manage the stress in your life?:_____

What is your current level of depression on a daily basis (on a scale of 1-10 where 10 is the highest)?_____
What is your current level of anxiety on a daily basis (on a scale of 1-10 where 10 is the highest)?_____

Alcohol or Substance Use (CAGE/CAGE-AID) Please describe your use of the following:
Do you drink alcohol? □ Yes □ No How many drinks per day?_____ per week?_____
Do you use Drugs/Chemicals? □ Yes □ No What?_____How many times per day?_____ per week? _____

- In the last three months, have you felt you should cut down or stop drinking or using drugs? □ Yes □ No
- In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? □ Yes □ No
- In the last three months, have you felt guilty or bad about how much you drink or use drugs? □ Yes □ No
- In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs? □ Yes □ No

If you have had addictive use/substance abuse in the past? □ Yes □ No When was that?_____
Have you addressed this in treatment, therapy, or support groups? □ Yes □ No _____

Relationship Information
Current Relationship Status: □ Single □ Dating □ Engaged □ Married □ Partnered □ Domestic Partnership
□ Civil Union □ Separated □ Divorced □ Partner or spouse deceased □ Other_____
Total number of marriages: _____ Total number of Divorces: _____
Sexual Orientation:_____ Comments:_____
Name of Spouse/Partner:_____Age:_____
Are you living together? □ Yes □ No How long have you been together?_____ Married how long? _____
What is your current living situation? □ Own home □ Rent □ Live with Family/Friend □ Other_____

How would you describe your relationship?:_____
_____
What are your relationship strengths?:_____
_____
Do you feel safe in your relationship(s)? □ Yes □ No Explain:_____
_____

Couple Concerns: Do you have any concerns in your current relationship? (Please check all that apply):
□ Alcohol Use/Drug Use (□ my use □ my partner's use) □ Concerns about Children □ Disagreeing about Relatives □ Disagreeing about Friends □ Feeling Distant □ Fighting □ Financial Concerns □ Family Concerns □ Health or Mental Health Concerns □ Issues of Power/Control □ Infidelity (□ me □ my partner) □ Loss of Fun □ Sexual Concerns □ Lack of Intimacy □ Safety Concerns □ Violence □ Work □ Other_____
Comments:_____
Are you engaged in any current relationships that you experience as abusive? □ Yes □ No □ Emotionally □ Verbally □ Physically (pushing, shoving) □ Physically (hitting, slapping, punching) □ Sexually □ Pattern of betrayal □ Other_____

Please describe any past relationships of significance:_____
_____

Sexual History
Please list any sexual health problems or concerns (Please put **C-Current and/or P-Past** for all that apply to you):

__Abortion	__Pain with Intercourse	__Sexuality Concerns
__Engaging in sexual behavior that you don't like	__Pornography Concerns	__Sexually Transmitted Infection(s)
__Infertility Problems/Concerns	__Sexual Assault	__Unwanted Pregnancy(s)
__Loss of Interest in Sex	__Sexual Trauma	__Other:_____

__Other problems that keep you from enjoying sex?:_____
How satisfying is your sex life? 1 2 3 4 5 (1 worst 5 best)

Family Information

Children	Age	Living Yes	Living No	Resides with you? Yes	Resides with you? No
_____	_____	□	□	□	□
_____	_____	□	□	□	□
_____	_____	□	□	□	□
_____	_____	□	□	□	□
_____	_____	□	□	□	□

Please list anyone else that currently lives with you?_____

Family of Origin --Please list all significant parental relationships

Name	Age	Living Yes	Living No	Resides with you? Yes	Resides with you? No
Mother:_____	_____	□	□	□	□
Father:_____	_____	□	□	□	□
Step-Mother:_____	_____	□	□	□	□
Step-Father:_____	_____	□	□	□	□
Other:_____	_____	□	□	□	□
Other:_____	_____	□	□	□	□

If your **parent is deceased**, how old were you when he/she died?_____

Are your parents: Currently legally married? □ Yes □ No How long? _____
Separated? □ Yes □ No How long?:_____ Parents divorced? □ Yes □ No How long?:_____
Mother remarried # of times:_____ How long?:_____ Father remarried# of times:_____ How long?:_____
Where do your parents live?_____

Brothers and Sisters **(Include Yourself):**

Name	Describe Relationship	Age	Living Yes	Living No
_____	_____	_____	□	□
_____	_____	_____	□	□
_____	_____	_____	□	□
_____	_____	_____	□	□
_____	_____	_____	□	□
_____	_____	_____	□	□
_____	_____	_____	□	□

Where did you grow up? And who did you live with? (Please list all places and people):_____
_____

How would you describe your family/family-relationships as you were growing up?:_____
_____

How would you describe your family/family-relationships now?:_____
_____

Development History
Are there special, unusual, or traumatic circumstances that affected your development? □ Yes □ No
If yes, please describe: _____
Do you have a history of being abused? □ Yes □ No
If yes, which type(s): ____ Sexual ____Physical ____Verbal ____Emotional ____Neglect
Is there anything else that happened to you in your childhood that you consider abuse?:_____
_____

Did anyone in your family of origin experience childhood abuse? □ Yes □ No If yes, Whom:_____
_____

Do you know anyone that committed suicide? □ Yes □ No If yes, Whom:_____

Family Mental Health and Health History
Has anyone in your family of origin have any mental health issues? □ Yes □ No If yes, whom:_____
_____

Please list any family history of medical problems, indicate whom:_____
_____

Your Current Employment Status
____Full Time ____Part Time ____Temporary ____Laid off ____Disabled
____Retired ____ Social Security ____Student ____Other (please describe):_____

Job history-please begin with most recent

Occupation	Employer	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any concerns about your work?:_____
_____
Do you enjoy your work? □ Yes □ No On a scale of 1-10, how stressful is your work?:_____
What is stressful about your current work?_____

Culture/Ethnicity
To which cultural or ethnic group, if any, do you consider you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? □ Yes □ No If yes, please describe: _____
_____
Are there any aspects of your culture or ethnicity that you would like me to know?_____
_____

Education
What is your highest level of education? _____Where did you go to school?_____

School	Degree	Date Graduated
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other training: _____

Are you currently a student? □ Yes □ No If yes: full time or part time? (circle) School Attending and program?
_____
_____

Spiritual/Religious
Are you affiliated with a religious or spiritual group? □ Yes □ No If **yes,** please describe: _____
_____
How important to you are religious or spiritual matters? (Please circle): Not at All A Little Somewhat Very
Did you grow up within a religious or spiritual group? □ Yes □ No If **yes,** please describe: _____
_____
Would you like your religious/spiritual beliefs included in your counseling? □ Yes □ No If yes, please describe:_____
_____

Military
Do you have military experience? □ Yes □ No Do you have combat experience? □ Yes □ No
Location: _____
Branch: _____ Enlisted date: _____
Date of discharge: _____Type of discharge:_____Rank at discharge: _____
Do you have family members in the military? □ Yes □ No Who?:_____

Legal Issues
Are you involved in any active legal cases (traffic, criminal, civil)? □ Yes □ No If **yes**, please describe and include the charges and court and hearing/trial dates:_____
_____
Do you have involvement with any of the following people or services? □ Yes □ No If **yes**, please circle all that apply: County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litem
Please describe:_____

Additional Personal Information
Briefly describe your current support system/resources e.g. family, friends, organization social workers, community support organizations, church groups, and/or 12 step programs:_____
_____

What do you consider to be some of your personal strengths?: _____
_____

What do you consider to be some of your areas of growth?:_____
_____

Do you have hobbies or special interests? □ Yes □ No Describe:_____
_____

Is there anything else that you would like me to know about you?:_____
_____

Do you have any resistance, fears, or questions you are aware of entering our work together?:_____
_____

Is there anything else that you think would help you to have a positive therapy experience?:_____
_____

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my counselor of any changes in my personal information.

Client Signature:_____ Date:_____