

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 (doctor's name)	Prescribed for (reason)	Dates	Helpful?
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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Past Mental Health Treatment

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

Do you experience the following patterns?

- Efforts to avoid real or perceived abandonment Yes No
- Intense/unstable relationships Yes No
- Unstable self-image or sense of self Yes No
- Using external coping methods in an addictive, impulsive, and/or excessive way, or as a way of coping, e.g.: excessive use of alcohol, drugs, tobacco, food, work, sex, shopping, spending money, gambling, cleaning, exercise, hoarding, reckless driving Yes No
- Suicidal gestures, threats or behavior, or self-harm Yes No
- Mood swings, intense emotion, or strong emotional reactions (includes irritability, anxiety) Yes No
- Feelings of emptiness Yes No
- Intense anger or difficulty controlling anger Yes No
- Feeling paranoid when you are stressed or having dissociative incidents Yes No

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 medications for medical conditions? Yes No

Medication and Dosage	Prescribed by (doctor's name)	Prescribed for (reason)	Dates	Helpful?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any current vitamin, herbal, or homeopathic supplements that you use on a regular basis and who prescribed them for what condition(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? _____
How do you currently manage the stress in your life? _____
What are your current coping mechanisms/strategies? _____

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? _____

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 Concerns
 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 _____
Comments: _____

Please describe any past relationships of significance: _____

Living Situation

What is your current living situation? Own Home Rent Other: _____
Who do you live with? Spouse Significant Other Family Roommate(s) Friend(s) Other: _____
How long lived in current living situation? _____
Do you own co-own your home? Yes No With Whom? _____ How Long? _____
Do you have any problems with your current living situation? _____

Do you have any concerns regarding your living situation? _____

Family Information

Children	Age	Living		Resides with you?	
		Yes	No	Yes	No
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list anyone else that currently lives with you? _____
 Do you have any pets? Yes No Describe: _____

Sexual History

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Pain with Intercourse | <input type="checkbox"/> Sexuality Concerns _____ |
| <input type="checkbox"/> Engaging in sexual behavior that you don't like | <input type="checkbox"/> Pornography Concerns | <input type="checkbox"/> Sexually Transmitted Infection(s) |
| <input type="checkbox"/> Infertility Problems/Concerns | <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Unwanted Pregnancy(s) |
| <input type="checkbox"/> Loss of Interest in Sex | <input type="checkbox"/> Sexual Trauma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other problems that keep you from enjoying sex? _____ | | |

How satisfying is your sex life? 1 2 3 4 5 (1 worst 5 best)

Family of Origin --Please list all significant parental relationships

Name	Age	Living		Resides with you?	
		Yes	No	Yes	No
Mother: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Step-Mother: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Step-Father: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your parent is deceased, how old were they when he/she died? _____
 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 now? City: _____ State: _____ How long? _____

Brothers and Sisters (Include Yourself):

Name	Describe Relationship	Age	Living	
			Yes	No
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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 ___ Not Working
___ Unemployed ___ Retired ___ Social Security ___ Student ___ Other: _____

Job history-please begin with most recent
Occupation

Employer

Dates

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? _____

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? _____

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: _____

Military Service

Are you currently serving in the military? Yes No Full Time: Yes No Part-time: Yes No
Branch: _____ Location: _____
Enlisted Date: _____ Job/Occupation: _____
Do you have combat experience? Yes No Where: _____
Have you served in the military in the past? Yes No How long were you in the military? _____
Branch: _____ Location: _____ Enlisted Date: _____
Date of Discharge: _____ Type of Discharge: _____ Rank at Discharge: _____

Do you have family members in the military? Yes No Who? _____

Spiritual/Religious

Are you affiliated with a religious or spiritual group? Yes No If yes, please describe: _____

Did you grow up within a religious or spiritual group? Yes No If yes, please describe: _____

How important were religious or spiritual matters to your family growing up? Not at All A Little Somewhat Very
Describe: _____

Were there any difficulties or problems with religious or spiritual matters when you were growing up? _____

Do you have a history of religious/spiritual abuse in your past? Yes No If yes, please describe: _____

How important to you are religious or spiritual matters? Not at All A Little Somewhat Very
Would you like your religious/spiritual beliefs included in your counseling? Yes No If yes, 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? _____

Is there anything else that you would like me to know about your relationship(s)? _____

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: _____