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

□ Transforming Touch® □ Somatic Experiencing® □ EMDR □ Talk Therapy □ Attachment Therapy □ Internal Family Systems
□ Couples Therapy □ Sensorimotor Psychotherapy □ Other _____

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

_____

Are you <u>currently</u> 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 <u>Mental Health Medications</u>? □ Yes □ No

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

Past Mental Health Treatment

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

Have you taken any <u>Mental Health Medications</u> 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 □ Yes □ No
  (Circle all that apply) excessive use of alcohol, drugs, tobacco, food, work, sex, shopping, spending money, gambling, cleaning, exercise, hoarding, reckless driving, other_____
- Suicidal gestures, threats or behavior, or self-harm □ Yes □ No
- Mood swings, intense emotion, or strong emotional reactions (includes irritability, anxiety) □ Yes □ No
- Chronic 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 <u>medications for medical conditions</u>? □ 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? (*Please circle all that apply)*
Difficulty falling asleep Difficulty getting up in the morning Difficulty staying asleep Wake in the night Oversleep
How many hours of sleep do you get per night?_____Hours of uninterrupted sleep?_____
Do you take medication or supplements for sleep?_____What?_____

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?_____
How would you describe your diet?_____
What is your diet plan? DASH Gluten-Free Fat Restricted Flexitarian High Protein Intermittent Fasting
Low Protein Low-Carb Low-Fat Pescatarian Paleo Mediterranean Vegan Vegetarian Other_____
Are you under the care of a dietitian? □ Yes □ No Whom?_____
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):
□ Communication Issues □ Sexual Concerns □ Lack of Intimacy □ Feeling Distant □ Tired/Overwhelmed □ Fighting
□ Loss of Fun □ Lack of Appreciation □ Unrealistic Expectations □ Boredom □ Money/Finances Concerns □ Chores
□ Concerns about Children □ Parenting Differences □ Family Concerns □ Disagreeing about Relatives □ Disagreeing about Friends □ Different Core Values □ Religious Belief Differences □ Alcohol Use/Drug Use (□ my use □ my partner's use)
□ Health Concerns □ Mental Health Concerns □ Issues of Power/Control □ Trust Issues □ Jealousy Issues
□ Infidelity/Affairs (□ me □ my partner) □ Other_____
Comments:_____

Are you engaged in any current relationships that you experience as abusive? □ Yes □ No (Please check all that apply):
□ Pattern of betrayal □ Emotionally □ Verbally□ Physically (pushing, shoving) □ Physically (hitting, slapping, punching)
□ Sexually □ Other_____Comment_____
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 Yes	Living No	Resides with you? Yes	Resides with you? No
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

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):

___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 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 was he/she when they died?_____
How old were <u>you</u> 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/parent live now? City:_____ State:_____ How long?_____

Brothers and Sisters **(Include <u>Yourself</u>):**

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

If sibling is deceased, how old were you when he/she died?_____
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

Do you have a history of being abused? □ Yes □ No Age of Abuse:_____
If yes, which type(s): ____ Sexual ____Physical ____Verbal ____Emotional ____Neglect ____Other_____
Is there anything else that happened to you in your childhood that you consider abuse?_____
_____
Are there any special, unusual, or traumatic circumstances that affected your development? □ Yes □ No
If yes, please describe: _____
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 ____Unemployed ____Retired ____Not Working
____Student ____Disabled ____Other:_____

Job history-please begin with most recent

Occupation	Employer	Dates of Employment

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:_____
_____

Would you like prayer to be included in your counseling? □ Yes □ No

Additional Personal Information

Briefly describe your current support system/resources e.g., family, friends, organization social workers, community support organizations, support groups, 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)?_____
_____

When considering our work together, do you have any resistance, fears, or struggles that you are aware of?_____
_____

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:_____