New Client Intake Form:

Basic Information:

Date:

Patient Name:

Social Security Number:

Date of Birth:

Gender: [ ] Male [ ] Female

Ethnicity:

Home Address:

Home Phone Number:

May we leave a message? [ ] Yes [ ] No

Work Phone Number:

May we leave a message? [ ] Yes [ ] No

Mobile Phone Number:

May we leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:

Name of Guardian:

Address of Guardian:

Guardian's Home Phone:

May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone:

May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone:

May we leave a message? [ ] Yes [ ] No

Referral Source

Who referred you to our office, or how did your learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

History Information

Who is providing the history information?

[ ] The patient

[ ] The patient’s guardian

[ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you/child are experiencing and explain if possible:

[ ] Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)

[ ] Depression/Sad/Down feelings

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Hearing voices/Seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting

[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating

[ ] Excessive exercise

[ ] Indecisiveness about career

[ ] Job problems

[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy?

[ ] Yes [ ] No

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns?

[ ] Yes [ ] No

Medical History

List any current or important past medications

Medication & Dose:

Response to Medication:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

Explain any allergies you have:

Family History

Birth Location:

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father

[ ] Other:

List your siblings and describe your relationship with them?

Name (s)

Age

Gender

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Educational History

[ ] In regular classes

[ ] Home Study

[ ] Special Education classes

[ ] Advanced classes

[ ] Ever suspended

[ ] Placed in alternative school

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Occupational History

What is your current employment status?

[ ] Employed Full-Time

[ ] Employed Part-time

[ ] Unemployed

[ ] Self-employed

[ ] Student

[ ] Other

Are you satisfied with your employment?

If not, why?

Marital History

Which best describes your marital status?

[ ] Married, Date: ______

[ ] Never Married

[ ] Widowed, Date: _____

[ ] Separated, Date: _____

[ ] Divorced, Date:_______

[ ] N/A:_______

Are there presently any child custody issues involving you or your family?

[ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement?

[ ] Yes [ ] No

If yes please complete the following:

Case Worker's Name:

Phone:

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes

[ ] No

If you answered yes, please complete the following substance abuse history chart.

Substance(s) used:

Age of First Use

Frequency of Use: (Daily, Weekly, Monthly)

Amount Used:

Complete the following chart if you have ever received treatment for a substance abuse issue.

Name of Treatment Program

Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)

Date of Treatment (Month, Year)

Outcome (Any Clean time?)

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

______________________________ ______________________________

Signature of client or guardian Date