

New Client Intake Form

Clients Name: _____ Todays date: _____

Partner's Name (if being seen as a couple): _____

Address, City, State, Zip: _____

Home phone: _____ Work phone: _____

Private email address: _____

May I leave messages for you at home? Yes / No May I leave messages for you at work? Yes / No

Gender Expression: _____ Age: _____ Birth Date: _____ Relationship
Status _____Others Living in Home (name, age, relationship): _____

Highest Level of Education: _____ Occupation: _____

Client's Employer: (optional) _____

Emergency Contact: _____ Relationship to client: _____ Phone: _____

Referred by / How did you hear about our services? _____

May I acknowledge our meeting to any referral source? _____

Have you received previous counseling and /or substance abuse treatment: yes/ no

If Yes, Name & number of therapist/ Agency (optional): _____

Past Diagnoses? months / years in treatment: _____

Name & number of primary care physician or health practitioner: _____

Any current medical or mental health conditions being treated? _____

*Do we have your permission to discuss or receive treatment records and or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/ or to disclose or share our clinical information? Yes _____ No _____

Signature _____ Date _____

Personal & Family information

Ethnic identity & background _____ Current relationship status _____

My birth parents currently: married/ live together- separated- divorced- never lived together
one or both are deceased

Family of Origin [parents/ step parents, adoptive parents, siblings]

Name	Relationship to you	Age or deceased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Family & Household [partner/spouse, roommates, children]

Name	Relationship to you	Age or deceased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check all that apply: (History of)

Counseling _____ Alcohol dependence _____ Drug dependence _____

Chronic physical illness _____ Chronic mental illness _____ Depression _____

Anxiety _____ Eating Disorders _____ Domestic Violence _____

Sex Abuse and or incest _____ Psychiatric hospitalization _____ Suicide Attempts _____

(check all that apply)

. I use alcohol: never _____ less than once/ week _____ more than once /week _____ daily _____

. I use drugs: never _____ less than once/ week _____ more than once /week _____ daily _____

. I use tobacco: never _____ less than once/ week _____ more than once /week _____ daily _____

. I have experienced an unwanted sexual experience: recently _____ past sexual assault _____

Assault _____ date rape _____ rape _____ incest _____

. My sleep is: _____ hours a night

Frequent waking? (y/n) / Difficulty falling asleep? -(y/n) Staying asleep? _(y/n)

- . I am dissatisfied with my personal appearance? (y/n)
- . I have felt like or tried to hurt myself in the past____(y/n) I am currently hurting myself (y/n)
- . I have suffered a recent significant loss or death -(y/n)
- . I have suffered a recent relationship ending -(y/n)

I have experienced:

- medical complications at birth (y/n)_____
- serious head injury (or knocked out) (y/n)_____
- past learning disability or attention deficit/ hyperactivity disorder (y/n)_____
- permanent disability (if checked yes, please describe) (y/n)_____
- legal difficulties (if checked yes, please describe-) (y/n)_____

Current Concern(s): (circle all that apply)

Anger Decreased Energy Impaired Judgment Depressed Mood Elevated Mood
 Dissociative state Guilt Fear Hyperactivity Hallucinations: (auditory / visual)
 Obsessions Panic attacks Memory loss Oppositional Paranoia Substance Abuse
 Appetite disturbance (weight loss/ gain) Worthlessness Withdrawn Binging Purging
 Sleep struggles Relationship Conflict Racism Family Conflict Decreased sleep
 Physical fighting Learning disability Anxiety Grandiosity Compulsions Distractibility
 Poor Concentration Shame Homophobia Cultural Oppression Gender Identity Oppression

Medical History:

Are you taking your medication as prescribed?

Please list medications, dosage and frequency:

Illnesses: current and history:

Please state briefly your reasons for seeking services at this time:

What do you think may be getting in the way of you resolving your current struggles or concerns?

What are a few of your current goals that you wish to achieve while participating in counseling and how do you currently believe you can best achieve those goals?

How would you like things to be different after you have participated in counseling/ consultation?

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?

Other information you think may be useful in our therapeutic relationship?
