NEW CLIENT INTAKE FORM

GENERAL INFORMATION

Full Name: _____

Name you prefer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Gender Identity (optional): □ Male □ Female □ Other: _____

Sexual Orientation (optional): □ Bisexual □ Gay □ Hetero □ Lesbian □ Other: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Mailing Address or Post Office Box (if different from above): _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Email Address: _____ May I send a message here? □ Yes □ No

Home Phone: (_____)_____ May I leave a message here? □ Yes □ No

Cell Phone: (_____)_____ May I leave a message here? □ Yes □ No

Work Phone: (_____)_____ May I leave a message here? □ Yes □ No

EDUCATION/EMPLOYMENT INFORMATION

School Completed: □ High School □ GED College: □ AA □ BA/BS □ Post-Grad or Professional

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____

RELATIONAL INFORMATION

Current Romantic Relationship Status:

□ Single □ Partner (boy/girlfriend) □ Married □ Separated/Divorced □ Widowed □Engaged □ Polyamorous □ Other

Are You Content with Your Current Status? □ Yes □ No. If No, Briefly Explain: _____

_____

If Partnered/Married, How Long: _____ If Separated or Divorced, How Long: _____

With Whom Do You Currently Live? *(Check all that apply)*

□ Alone □ Spouse/Partner □ Children (#___) □ Parent(s) □ Sibling(s) □ Boyfriend/girlfriend

□ Other: _____

PARTNER INFORMATION

Full Name: _____

How Long Have You Known Your Partner? _____ Age: _____

Gender Identity (optional): □ Male □ Female □ Other: _____

Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ AA □ BA/BS □ Post-Grad or Professional

How Would You Describe this Person? _____

_____

CHILDREN

List Your Children (Living or Deceased) as well as Children You Have Placed for Adoption:

Name:	Current Age:	Relationship (biological/step/adopted):	Living with you?

Have You or Your Partner Ever Had a Miscarriage or Medical Abortion? □ Yes □ No. If yes, When: _____

FAMILY OF ORIGIN (FOO) - (Who you grew up with)

Please list family members and describe your relationship with them.

Name:	Gender:	Age:	Relationship to you:	Description:

PRESENTING ISSUES

Please tell me why you are seeking counseling: _____

_____

_____

_____

How long have these concerns been causing you distress? _____

Please check the boxes below if you've had problems or concerns with any of the following:

Aggressiveness	□ Past □ Present	Loneliness	□ Past □ Present
Alcohol Abuse	□ Past □ Present	Loss of Control	□ Past □ Present
Anger	□ Past □ Present	Making Decisions	□ Past □ Present
Anxiety	□ Past □ Present	Memory	□ Past □ Present
Apathy	□ Past □ Present	Nervousness	□ Past □ Present
Bad Dreams	□ Past □ Present	Pain	□ Past □ Present
Change in Appetite	□ Past □ Present	Panic	□ Past □ Present
Compulsivity	□ Past □ Present	Physical Abuse	□ Past □ Present
Depression	□ Past □ Present	Racing Thoughts	□ Past □ Present
Difficulty Breathing	□ Past □ Present	Rapid Heart Rate	□ Past □ Present
Digestive Upset	□ Past □ Present	Seeing Things	□ Past □ Present
Dizziness	□ Past □ Present	Serious Illness	□ Past □ Present
Drug Abuse	□ Past □ Present	Sexual Abuse	□ Past □ Present
Eating Problems	□ Past □ Present	Sexual Problems	□ Past □ Present
Emotional Abuse	□ Past □ Present	Sleep Trouble	□ Past □ Present
Fatigue	□ Past □ Present	Social Anxiety	□ Past □ Present
Fears	□ Past □ Present	Stress	□ Past □ Present
Finances	□ Past □ Present	Trauma	□ Past □ Present
Grief/Loss	□ Past □ Present	Trouble Focusing	□ Past □ Present
Guilt	□ Past □ Present	Trouble Relaxing	□ Past □ Present
Headaches	□ Past □ Present	Unhappiness	□ Past □ Present
Hearing Noises/Voices	□ Past □ Present	Unwanted Thoughts	□ Past □ Present
Hopelessness	□ Past □ Present	Verbal Abuse	□ Past □ Present
Impulsive Behavior	□ Past □ Present	Weakness	□ Past □ Present
Legal Matters	□ Past □ Present	Work Problems	□ Past □ Present
Other	□ Past □ Present	Other	□ Past □ Present

Are You Currently Experiencing Any Suicidal Thoughts? □ Yes □ No

Have You Experienced Them in the Past? □ Yes □ No ---- Have You Ever Attempted Suicide? □ Yes □ No

If Yes, When and How: _____

Have you had any previous psychiatric hospitalizations? □ Yes □ No

If Yes, When and where: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide? □ Yes □ No

If Yes, When and Who: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (_____)_____

Address: _____ City: _____ Zip: _____

Would you like to sign a release of information (ROI) for use between me and your doctor? □ Yes □ No □ Unsure

If Yes would you like any specific information restricted? □ Yes □ No □ N/A

Please indicate on the following scale how comfortable you are with revealing personal information to this doctor:

Not at all 1 - - - - - - 2- - - - - - - 3 - - - - - - - 4 - - - - - - -5 - - - - - - 6 - - - - - -7 - - - - - 8 - - - - - - - 9 - - - - - - -10 Completely

Are You Currently Receiving Medical Treatment For A Specific Concern? □ Yes □ No □ Unsure

If Yes or Unsure, Please Specify: _____

List any Previous Conditions, Illnesses, Surgeries, Hospitalizations, or Injuries you've had:

_____

Current Medications: Dosage: Taking for:

_____

_____

_____

SOCIAL SUPPORTS

Do You Have a Personal Support System? □ Yes □ No □ Unsure

If Yes, Who: _____

Do You Regularly Attend a Place of Worship? □ Yes □ No □ Unsure

If Yes, Where: _____

How important are spiritual matters to you? □ Not at all □ Somewhat □ Very much

How or from whom did you hear about my services? Specificity is preferred:_____

If referred by a friend or acquaintance, may I tell them thank you?_____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signed: _____ Date: _____