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New Client Intake Form

Today's Date_____
Name_____
Home
Address_____C
ity_____ State_____ZIP_____

Home Phone_____ Cell_____ Work_____
Marital Status_____ Gender: M F Other

E-mail_____ Age _____
DOB_____ Place of Birth_____
Grew up in_____
Religion_____Race/Ethnicity_____

Referred By_____

Emergency Contact

Name_____ Relationship_____

Address(City/State/ZIP)_____

H-Phone_____ W-Phone_____

MEDICAL HEALTH CARE

Current Health: Great Good Fair Poor

Are you currently receiving medical health care? *Y* *N*
If yes, where and from whom?_____
Health Problems_____
_____
_____
_____Sur
geries_____
_____
Please list all medications, herbs, supplements, and vitamins you are taking and what they are treating.
_____
_____
_____
_____
_____
_____
_____

How would you describe your sleep? Good Fair Poor

Please
explain_____

_____
_

How would you describe your eating habits ?Good fair Poor

MENTAL HEALTH HISTORY

Have you ever received mental health treatment? *Yes* *No*

Age Dates Condition Treated Diagnosis Inpatient or Outpatient

_____
_____
_____
_____
_____

Are you taking medications for mental health at present? *Yes* *No*
If so, name, dosage, and condition treated:

_____
_____
_____
_____
_____

Suicidal History: Have you had repeated thoughts about wanting to die or committing suicide? *Yes* *No*

Have you made a suicide attempt? *Yes* *No*

If so, please explain:

_____

_____

_____S

elf Harm History: Have you ever hurt yourself on purpose? *Yes* *No* If so, please explain:

_____

_____

_____

EDUCATION

How far did you go in school? (Circle the highest grade you completed)

Grade School *High School* *College* *Graduate/Professional School*

Major or Area of Study: _____

WORK HISTORY

List your jobs, age, titles or type of work, why you left and any other special circumstances.

Age From/ To Job Title Reason Left:

_____

_____

_____

_____

_____

RELATIONSHIP and MARITAL HISTORY

Please list your significant partners/spouses and years spent together below.

_____
_____
_____
_____
_____

CHILDREN/STEP-CHILDREN

Please list all your children and stepchildren (including deceased) and indicate description of your relationship

Name Age Relationship

_____
_____
_____
_____
_____

GRANDPARENTS, PARENTS, STEPPARENTS, SIBLINGS, OTHER CARE GIVERS

Below is a list of major health and behavioral problems that may have happened in your family and which may have had or still have some level of emotional impact on you. Problem areas include:
Drug or Alcohol Abuse, Gambling, Medical Disability, Mental Illness, OCD, Anger, Anxiety, Depression, Workaholic, Unemployed, Physically Abusive to You, Physically Abusive to Other, Verbally Abusive to You, Verbally

Abusive to Other, Neglectful, Critically, Focused on Money, Committed Suicide, Divorced, Died, Left Home

List caregiver, problem affecting you, your age when affected, any specific incident:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SIGNIFICANT EVENTS

Briefly describe the critical life incidents, unusual happenings, or traumatic events, losses or stressors, in your life, that left their mark on you, and sometimes leave you feeling upset or otherwise uncomfortable. Give your age and briefly describe life event.

Age *Event*

_____
_____
_____
_____
_____
_____

_____
_____
_____

FINANCIAL/LEGAL

Do you have any financial (money) problems? Y N
If yes, what problems do you have?

_____
_____
_____
_____
_____

Do you have any current legal problems? Y N
If yes, what problems do you have?

_____
_____
_____
_____
_____

Have you had legal problems in the past? Y N
If yes, what problems did you have?

_____
_____
_____

_____
_____

SOCIAL/RECREATIONAL

What activities do you engage in for fun?

_____
_____
_____

Do you exercise? Y N If so, what kind and how often?

_____
_____
_____

Who is part of your support system?

_____
_____
_____

Do you attend a support group? Y N Please describe:

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

How will you know if you've achieved these goals?

_____

_____

_____

SELF-DESCRIPTION

Circle all the that following describe you. Add others which may apply.

Easily bored Angry Assertive Avoidant Competitive

Honest Perceptive Procrastinator Low Self-esteem

Dependent Loner Anxious Depressed Caring Judgemental

Hard Working Con Artist Unworthy Workaholic Responsible

Law-abiding Isolated Friendly Athletic Greedy Impulsive

Immature People pleaser Intelligent Shy Easily frustrated

Worrier Happy Motivated to achieve Outgoing Lazy Lonely

Impatient Risk Taker Good person Critical Compassionate

Sad Fearful Agitated Wise Caregiver Overachiever

Humorous Controlling Self-loathing Protective Generous

What else do you want me to know about you?

_____

_____

THANK YOU for taking time to share this important information with me!!!