New View Recovery, LLC

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INTAKE FORM

Date taken: _____ **Taken by:**_____

Caller's full name: _____ **Referred by:** _____

Treatment Type: **Identified Client(s):**

☐ Individual 1) Name:_____ Role:_____ Age: _____ DOB:_____ Race: _____

☐ Couples 2) Name:_____ Role:_____ Age: _____ DOB:_____ Race: _____

☐ Family 3) Name:_____ Role:_____ Age: _____ DOB:_____ Race: _____

☐ Group 4) Name:_____ Role:_____ Age: _____ DOB:_____ Race: _____

5) Name:_____ Role:_____ Age: _____ DOB:_____ Race: _____

Current Relationship Status: __ Single __ Engaged __Married __ Partnered __Separated __Divorced __Widowed ___Poly/Open

If in Relationship How Long ___ Number of Previous Marriages/ Relationships___ Is the client content with current marriage? ___

Address: _____ **City:** _____ **Zip:** _____

Primary phone: _____ **Message okay? ____ Yes ____No**

Alternate phone: _____ **Message okay? ____ Yes ____No**

Email address: _____ **Message okay? ____ Yes ____No**

Primary presenting problem:_____

_____

Why have you decided to come to counseling now? / What do you hope to gain or change by coming to counseling? _____

_____

Assess appropriateness for services at NVR:

Suicidal ideation (thoughts of hurting self)**:** __N __Y	**Homicidal ideation** (thoughts of hurting others)**:** __N __Y	**Domestic Violence:**
If yes, when was the last time? _____	If yes, when was the last time? _____	Has your partner ever acted violently towards you? __
What did you do? _____	What did you do? _____	Have you ever acted violently towards your partner? __
Plan:_____	Plan:_____	
Intent:_____	Intent:_____	If yes then: Has there been any charges filed? __
Previous attempts (#)? ____ How long ago? _____	Previous attempts (#)? ____ How long ago? _____	
Hospitalized? Y / N -- Voluntary / Involuntary (circle)	Hospitalized? Y / N – Voluntary / Involuntary (circle)	24-Hour Crisis Hotline (407) 886-2856

****Referral – Lifeline of Central Florida Hotline (407) 425-2624, Teen Hotline: 407-841-7413 National Hope Line Network: 800-SUICIDE (1-800-784-2433)**

Previous Psychiatric/Psychological History:

Therapist:_____ Location: _____ Dates: _____ Phone #: _____

Previous Dx and/or Tx:_____

_____

Current medications: __N __Y if yes then: Prescribing physician: _____ Phone: _____

List Psychotropic Medications & Dosage: _____

Education/Work History/Legal:

Last year of completed education: _____ Are you currently in school: __Y__N If yes what level: _____

Are you currently employed? Y/N If yes what is your occupation? _____ Length of Employment _____

Are you currently involved in the legal system? _____

CARE/PROGRAMS REQUIRED BY A COURT OF LAW, COMPETENCY EVALUATIONS, CHILD CUSTODY EVALUATIONS NOT provided by this office.

Possible Areas of Concern					
Individual Adult		Child/Adolescent		Couples/Marriage Counseling	
☐ Depression	☐ Emotional Stress	☐ Depression	☐ Emotional Stress	☐ Relational Problems	☐ Domestic Abuse
☐ Anxiety	☐ Assertiveness	☐ Anxiety	☐ Assertiveness	☐ Divorce	☐ Infidelity Issues
☐ Panic Attacks	☐ Anger Management	☐ Panic Attacks	☐ Anger Management	☐ Child-Related Problems	☐ Blended Family Issues
☐ Social Problems	☐ Death/Loss/Grief	☐ Social Problems	☐ Death/Loss/Grief	☐ Communications	☐ Work Problems
☐ Low Self-Esteem	☐ Unemployment	☐ Low Self-Esteem	☐ School Behavior		
☐ Physical Illness	☐ Work Problems	☐ Physical Illness	☐ Underachievement	Family Counseling	
☐ Hallucinations	☐ Career Counseling	☐ Defiance	☐ Risky Behavior	☐ Blended Family Issues	☐ Death/Loss/Grief
Sexual Abuse as a ☐ Child ☐ Adult _____		☐ Sexual Abuse _____		☐ Parent-Child Problems	☐ Sibling Problems
Physical Abuse as a ☐ Child ☐ Adult _____		☐ Physical Abuse _____		☐ Separation Problems	
Emotional Abuse as a ☐ Child ☐ Adult _____		☐ Emotional Abuse_____			

Other (please describe):_____

Are you currently involved in the legal system? _____

Substance Use:

Do you consume alcohol beverages? ___ Past ___ Current	**Have you ever used: ___ Past ___ Current**
If yes, how many times a week? ____ How much? ____ How long? ____	☐☐ Cannabis ☐☐ Opiates ☐☐ Stimulants ☐☐ Depressants ☐☐ Other
Cut down? ____ Annoyed? ____ Guilty? ____ Eye-opener? ____ (2/4) assess	☐☐ Prescription drugs ☐☐ Barbiturates ☐☐ Inhalants ☐☐ Hallucinogens
Have you ever been convicted of an alcohol related crime? Y/N	If yes, how many times a week? ____ How much? ____ How long? ____
Has drinking ever interfered with other parts of your life? Y/N	Have you ever been convicted of a substance related crime? Y/N
	Has using ever interfered with other parts of your life? Y/N

Have you ever received treatment for your Substance Use? Y/N In/Outpatient Completed? Results? Mandated?

Currently sober/in recovery? Y/N If substance abuse is a concern, then refer to Center for Drug Free Living (407)245-0014

******IF CLIENT IS A MINOR******

If the client is a minor, **are you the primary custodial parent?** ____ YES ____ NO _____ SHARED

Legal Problems/Child Abuse: _____

Emergency contact: _____ **Emergency phone #: _____**

Persons at Home:	**Role:**	**Age:**		**Role:**	**Age:**
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____
4. _____	_____	_____	8. _____	_____	_____

What time is client looking to come in? ☐ Daytime ☐ Evening

Scheduled: _____ Date: _____ Time: _____

Additional scheduling notes _____