Present Wellness Counseling, LLC
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New Client Intake Paperwork

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy. Please bring this paperwork with you to your initial intake session.

Client Information

Name _____ DOB _____ Age _____

Address _____

Phone Number _____ May I leave a message at this number? _____

Phone Number _____ May I leave a message at this number? _____

May I send you text message reminders of upcoming appointments at one of these numbers? _____

Email Address _____ May I contact you at this email address? _____

Occupation and Employer _____

Sex _____ Gender _____ Sexual Orientation _____

Relationship Status _____ Partner's Name (If applicable) _____

Emergency Contact Name and Phone Number _____

Presenting History

Presenting Issue that brings you to counseling: _____

_____

_____

How long has this been an issue? _____

How intense is the problem? (1 being not intense and 10 being very intense):_____

What goals would you like to achieve through counseling?

_____

_____

Psychiatric History:

I have received treatment for: ( ) Substance Abuse ( ) Mental Health Issues ( ) Both

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? _____

Please list any previous treatments for mental health, including outpatient counseling, psychiatry, or hospitalization:

_____

_____

List any Diagnosis (treated, resolved, re-occurring etc. as well as the approximate date you received this diagnosis)

_____

Do you or have you ever engaged in a recovery community, such as AA, NA, ALANON, etc? If so please explain.

_____

Please list any current psychiatric medications:

Medication	Date Prescribed	Purpose	Dosage

Have you had suicidal thoughts recently? ( ) frequently ( ) sometimes ( ) rarely ( ) never
Have you had them in the past? ( ) frequently ( ) sometimes ( ) rarely ( ) never
Have you ever attempted suicide? _____

Biomedical Health History

Do you currently have a primary physician or any other medical health specialists?

_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____

_____

Please list any medications for physical health concerns:

Medication	Date Prescribed	Purpose	Dosage

Are you having any problems with your sleep habits? If so, please describe: _____

_____

How many times per week do you exercise? _____ Approximately how long each time? _____
Are you having any difficulty with appetite or eating habits (Eating too little, too much, bingeing, restricting)?

_____

Do you or have you ever regularly consumed alcohol? If so, please describe how much and how often?

_____

Do you or have you engaged in recreational drug use? If so, please describe how much and how often?

_____

Do you or have you used tobacco products? If so, how much and how often? _____

Family History

Are you currently in a romantic relationship? _____ If yes, how long have you been in this relationship?_____
On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____
Do you have any children? Ages? _____
Do you have any behavioral or emotional concerns about any of your children at this time? _____

_____

How would you describe your relationship with your family? ( ) Excellent ( ) Good ( ) Fair ( ) Poor
How would you describe your support system at this time? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Is there a history of psychiatric concerns in your family? If yes please explain: _____

_____

Is there a history of substance abuse in the family? If yes please explain: _____

_____

Is there a history of abuse/domestic violence in the family? If yes please explain: _____

_____

Do you identify having any experiences as a child or adult that caused trauma for you? _____

_____

Cultural and Spiritual

Do you consider yourself to be religious and/or spiritual? _____

Are you affiliated with any particular religion or faith community? _____

If so, how frequently to you engage in activities within this community? _____

Are there any religious or cultural considerations you would like for me to be aware of for you? _____

_____

Court, Legal or Social Service History

Are you or your family involved with DHR, or have history with DHR or court custody issues?

_____

Judge: _____ DHR Worker and Number: _____

Do you have any previous arrests? If so, do you have a current legal case pending?

_____

Attorney: _____ Judge: _____

Additional Information

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

What effective coping strategies do you utilize? _____

_____

Is there anything else you would like for me to know or consider?_____

_____

By signing below, I agree that the information I have listed is, to the best of my ability, accurate. I understand that this information will be held confidential by Present Wellness Counseling, LLC.

Client Signature _____ Date _____

Client Name: _____ **Date:** _____

Checklist of Concerns

(please check any relevant concerns that apply currently or within the past 3 months)

THOUGHTS/FEELINGS/MOOD

- ❑Anger/frustration/hostility
- ❑Anxiety, nervousness
- ❑Attention, concentration, distractibility
- ❑Confusion
- ❑Depression
- ❑Disliking others
- ❑Emptiness
- ❑Euphoria
- ❑Excessive worry
- ❑Failure
- ❑Fatigue
- ❑Fear
- ❑Grieving (death, loss, divorce, etc)
- ❑Guilt
- ❑Hearing things other people don't
- ❑Homicidal thoughts
- ❑Intrusive thoughts
- ❑Obsessive thoughts
- ❑Judgment problems
- ❑Memory difficulties
- ❑Negative thoughts
- ❑Oversensitivity to criticism
- ❑Oversensitivity to rejection
- ❑Panic attacks
- ❑Perfectionism
- ❑Loss of appetite
- ❑Sadness
- ❑Seeing things other people don't
- ❑Self-centeredness
- ❑Self-esteem (low)
- ❑Shyness
- ❑Spiritual, religious, or moral issues
- ❑Stress
- ❑Sudden mood changes
- ❑Suicidal thoughts
- ❑Suspiciousness
- ❑Temper problems

BEHAVIOR

- ❑Aggression, violence
- ❑Alcohol use
- ❑Argumentative
- ❑Avoidant
- ❑Compulsive behavior/rituals
- ❑Controlling
- ❑Decreased/lack of sexual interest
- ❑Dependency
- ❑Destruction of property
- ❑Drug use: prescription, over-the-counter, street
- ❑Eating problems
- ❑Financial problems, debt
- ❑Gambling
- ❑Hyperactivity
- ❑Internet problems
- ❑Irresponsibility
- ❑Isolation
- ❑Legal problems
- ❑Letting others take advantage of you
- ❑Lying
- ❑Not able to relax
- ❑Preoccupation with sex
- ❑Sleep difficulty
- ❑Procrastination
- ❑Purging
- ❑Overeating
- ❑History of running away
- ❑Self destruction/sabotaging
- ❑Self-neglect
- ❑Sexual dysfunction
- ❑Smoking
- ❑Stealing
- ❑Threats
- ❑Weight, gain/loss
- ❑Withdrawal from others
- ❑Loss of interest in hobbies

FAMILY & RELATIONSHIPS

- ❑Affair
- ❑Childhood issues
- ❑Divorce
- ❑Friendships
- ❑Housework/chores
- ❑Interpersonal conflicts
- ❑Parenting
- ❑Problems w/ child(ren)
- ❑Problems w/ parents
- ❑Problems w/ partner
- ❑Separation

ABUSE

- ❑Abuse of alcohol
- ❑Abuse of drugs
- ❑Physical abuse by another
- ❑Physical abuse of another
- ❑Sexual abuse by another
- ❑Sexual abuse of another

WORK & SCHOOL

- ❑Absenteeism
- ❑Career concerns, goals, choices
- ❑Difficulty with coworkers
- ❑Difficulty with supervisor
- ❑Performance
- ❑Tardiness
- ❑Procrastination
- ❑School problems

OTHER CONCERNS

- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____