New Client Intake

Personal Information

Client Name _____ Todayôs Date: _____

Home address _____City/State/Zip_____

Cell phone # _____ Is it okay to identify who is calling or leave a message? _____
Home phone # _____ Is it okay to identify who is calling or leave a message? _____

Email _____

Age _____ Date of Birth _____ Gender _____ Marital Status _____

Primary Language _____ Ethnic Background_____

Occupation _____Employer_____
Work address _____ City/State/Zip _____
Work phone # _____ Is it okay to identify who is calling or leave a message? _____

Person Responsible for payment _____ Relationship to client_____
Referred by _____

Emergency Contact Name_____ Relationship to Client_____
Address_____ Phone _____

Areas of Concern
What issues/concerns caused you to seek treatment?
_____
_____
_____
_____

What are your specific goals for treatment?
_____
_____
_____
_____

Do you have any particular concerns/fears with regard to treatment?
_____
_____

Communication
I authorize any correspondence regarding my treatment, updates regarding my treatment and general information about programs (for example: educational, group therapy, classes) during and after completion of my treatment to my home mailing address or email address. ___ Yes ___No

Intake Information

Please indicate any problems with following:

__Sleep __Appetite __Memory __Difficulty w/ Focus __Fatigue __Sad mood
__Crying Spells __Isolating __ Loss of Interest in activities __
__Thoughts of self harm/suicide __Thoughts of hurting or killing others
__ Irritability/ Anger __Anxiety __ Panic Attacks __ Restlessness/Agitation
__Academic Problems __Work/Employment Problems __ Relationship Problems

If you marked any of the above, describe it and how long you have been experiencing problems

_____
_____
_____
_____

Have you ever attempted suicide? _____When?_____
Describe the circumstances that led to the attempt

_____
_____

Are you currently having any suicidal thoughts? Please describe

_____
_____

Medical History

Please describe any medical problems:

_____
_____

Any allergies, including allergies to medication?

_____

Any problems in development (birth complications, milestones, learning disabilities)?

_____

Any prior head injuries?

_____

Currently under doctorôs care? __Yes __No

Medications (include purpose of medication, dosage, name of person prescribing medication, length of time on the medication)

_____
_____
_____

Currently on Disability or workerôs Compensation? __Yes __No

Please describe your spiritual identity/orientation?

_____

Any legal issues/problems?

_____

Educational Background

Please indicate highest completed. Any learning disabilities, ADD/ADHD?

_____
_____

Personal and Family History

Current relationship and history of previous relationships

_____
_____
_____

Current or Family History of Domestic Violence? Child Abuse?

_____
_____

Current or Family History of Psychiatric Problems?

_____
_____

Family History of Substance Abuse?

_____
_____

Any prior psychotherapy? When, with whom and why?

_____
_____

Prior psychiatric care or hospitalization? When and Where?

_____
_____

Alcohol and Drug Use

Current use? What used and frequency:

_____
_____

Past use? What used and frequency

_____
_____

Military Background

Ever served in military? Combat or non combat? Honorable discharge?

_____

Work History

_____
_____

Financial Information:

Annual Household Income _____ Do you own or rent?_____

How do you intend to pay for treatment (check, cash, credit card, insurance)_____

If planning to use health insurance:

Name of insurance company_____ Telephone #_____

Policy #_____ Group #_____

Additional Information: Please provide any other information that may be relevant for treatment.