PARENT/GUARDIAN INFORMATION—ONLY IF APPLICABLE

Parent/Guardian Name: ___________________________ Phone Number: _______________________________

As the parent or legal guardian of ___________________________________, I authorize his/her treatment. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

____ ____

Signature Witness Signature

Date: _________________ Date: __________________

New Client Intake Form

Identifying Information

Name ___________________________ Age _______________________ Birth Date __________________

Address _________________________ City _______________________ State ______ Zip Code _____

Name you prefer to be called ___________________________________

Gender _____________________ Race ________________________

Single_____ Married____ Divorced____ Other____

Home Phone _____________________________ OK to leave message? Y/N

Cell Phone _______________________________ OK to leave message? Y/N OK to text? Y/N

Work Phone ______________________________ OK to leave message? Y/N

Email ____

How do you prefer that I contact you? ____

Emergency Contact _______________________Relation ______________________ Phone___________________________

How did you hear about this practice? ____

Do you plan to use insurance? Y or N Insurance Company Name____

Insurance ID #__________________________________ Group ________________________ Plan____________________

Primary Name on Account__________________________________

OR

Private Pay? Y or N

FOR PRIVATE PAY EITHER BRING A CHECK OR GIVE CREDIT CARD INFORMATION. Credit card WILL be charged within the week of the service. By giving a credit card number or card, you are authorizing payment. Please have sufficient funds in your account.

Presenting Problem

1. What is the main problem or issue that has motivated you to seek counseling at this time?
   ____
   ____
   ____
   ____
2. Describe how these issues have affected your ability to function (at home, at school, or at work).
   ____
   ____
3. Describe any physical symptoms. ____
   ____
4. If you have experienced learning difficulties in any educational setting, please explain.
   ____
5. What would you like to achieve through counseling? What are your counseling goals?
   ____

Strengths and Identified Opportunities for Growth

6. Who is a part of your support system? ______________________________________
7. What are your top 3 strengths?
   ____
   ____
   ____
8. Describe 3 areas of your life that you could grow in.
   ____
   ____
   ____

Family History

Please list family members from your family of origin, including their ages, marital history, and employment status. Then describe what your relationship was/is like with each person) close, distant, strained, etc.). If any have died, please record the year of death, the person's age, and your age at the time of that death.

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1. Marital Status: Single/Married/Separated/Divorced/Widowed/Dating/Other: ___________________________
2. If married, please give the name and age of your spouse and the date of your marriage. If you have been married before, please write the name(s) of your former spouse(s) and the date(s) of that (those) marriages(s). If in a serious dating relationship please give the name and age of that person and the length of that relationship.
   ____
   ____
   ____
3. Briefly describe your marital relationships(s) or serious dating relationship(s).
   ____
   ____
   ____
4. Do you have any children? ____Yes ____No If so, please list their names, ages, and describe your relationship with each.
   ____
   ____
   ____
5. Living situation (city, house or apartment, who currently lives with you).
   ____
6. Identify any mental health (such as depression, anxiety, post-traumatic stress, suicide attempts, etc.) or substance use disorder (such as alcohol, marijuana, cocaine/crack, methamphetamines, inhalants, hallucinogens, heroin/opiates, prescription drugs, cigarettes/cigars, caffeine, other) diagnoses in your family. Place a * by any mental health or substance use disorders that are current. Include also any in-patient care for substance abuse or mental health.

   Mother ____
   Father ____
   Stepmother ____
   Stepfather ____
   Siblings ____
   Grandparents ____
   You ____
   Other ____

Social History:

Please check your current status. ____ Employed ____Student _____Unemployed _____Disabled _____Retired

1. If employed and/or a student, where are you working and/or studying?
   ____
2. What is/was your position/occupation? ____
3. Level of education achieved (Check the highest one.)
   ( ) Elementary School
   ( ) Middle School
   ( ) High School Diploma
   ( ) Associate Diploma – area of study: ___________________________
   ( ) Bachelor's Degree – area of study: ___________________________
   ( ) Master's Degree – area of study: ___________________________
   ( ) Doctorate Degree – area of study: ___________________________
   ( ) Other qualification – area of study: ___________________________

4. Have you experienced or witnessed any of the following types of abuse: ___Yes ___No
5. If yes, please circle which types and describe what happened briefly.

   Physical Abuse ______________________________

   Emotional Abuse ______________________________

   Financial Abuse ______________________________

   Sexual Abuse ______________________________

   Spiritual Abuse ______________________________

   Neglect ______________________________

   Intimate Partner Violence ______________________________

   Other ______________________________

Health Information

1. Describe your health. ______________________________

2. List significant illnesses or injuries.______________________________

   ____

3. Primary Care Physician: ______________ Date of last medical exam: ______________

4. Result of last medical exam: ______________________________

5. List current medication and dosages. ______________________________

   ____

   ____

6. Have you ever seen a psychiatrist, psychologist, mental health practitioner or pastor for assistance? Y/N
   Describe your past experiences with any of these individuals, including dates and types of treatment.

   ____

   ____

   ____

7. Are you now having suicidal thoughts or have you ever? ___ Now ___ In the past ___Never
   If you have ever had suicidal thoughts, please describe for how long and what you have done to get help.______________________________

8. Are you now or have you ever engaged in self-harming behaviors (cutting, hitting, burning)? ___ Yes ___ No
   If yes, what type and for how long? ______________________________

Current Problems

Below is a list of problems and concerns that people sometimes have. Please identify any problem that has bothered you in the past two weeks with a number indicating the degree of severity (1=mild, 2=moderate, 3=severe).

____Trouble remembering things
____Feeling easily annoyed or irritated
____Pains in the heart or chest
____Feeling afraid
____Poor appetite
____Temper outbursts you could not control
____Feeling blocked in getting things done
____Feeling lonely
____Feeling blue
____Feeling no interest in things
____Feeling that people are unfriendly or dislike you
____Thoughts of ending your life
____Feeling that other watch or talk about you
____Trouble sleeping
____Difficulty making decisions
____Eating issues
____Legal issues
____Parenting concerns
____Homicidal thoughts
____Time management
____Poor social relationships
____Gambling
____Internet abuse
____Gender Identity
____Self-injury (cutting, hitting, burning)
____Feelings of anger
____Financial issues
____Conflict over control issues
____Marital issues
____Feeling hopeless about the future
____Trouble concentrating
____Feeling tense or keyed up
____Spells of terror or panic
____Feeling so restless you could not sit still
____Feelings of worthlessness
____Feelings of guilt
____Feelings of failure
____Feeling that something is wrong with your mind
____Unusual thoughts
____Physical health issues
____Relationship problems
____Feelings of insecurity
____Family conflicts
____Alcohol and/or drug use
____Grief
____Body image concerns
____Stress
____Physical abuse
____Spiritual concerns or confusion
____Forgiveness
____Suicidal thoughts
____Pornography
____Post Abortion
____Boundaries
____Sexual Abuse/Trauma
____Divorce Issues
____Conflict with authority
____Sexual issues

Spiritual Life

1. Do you happen to attend church regularly at this time? Y/N
   If so, where? ____
2. How does spirituality affect your life?
   ____
   ____
   ____

Please bring the completed form to your first appointment.