New Client Intake Form

Fields marked with an \* are required

**CONTACT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name \* |  | Last Name \* |  | Date \* |  |
|  |  |  |  |  | |
| Parent/Legal Guardian (if under 18) | | | | |  |
|  | | | | | |
| Email \* |  | Phone Number\* |  | May I leave a message? \*  (Circle your answer) | |
|  |  |  |  | YES | NO |
| Address | | | | | |
|  | | | | | |
| City |  | State |  | Zip Code | |
|  |  |  |  |  | |
| Emergency Contact \* |  | Relationship \* |  | Phone \* | |
|  |  |  |  |  | |
| Primary Care Physician \* |  | Address |  | Phone \* | |
|  |  |  |  |  | |
| Referred by (if any) | | | | | |
|  | | | | | |

**HEALTH INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender ID \* |  | Age \* |  | Date of Birth \* | |
|  |  |  |  |  | |
|  | | |  | (Circle your answer) | |
| Have you previously received mental health services? \* | | |  | YES | NO |
| Previous Practitioner Name |  |  |  | Date of Visit | |
|  | | |  |  | |
|  | | |  | (Circle your answer) | |
| Are you currently taking any prescription medication? \* | | |  | YES | NO |
| Current Medication |  |  |  | Date Prescribed | |
|  | | |  |  | |
|  |  |  |  | (Circle your answer) | |
| Have you ever been prescribed psychiatric medication? \* | | |  | YES | NO |
| Psychiatric Medication |  |  |  | Date Prescribed | |
|  | | |  |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How would you rate your current physical health? \* (Circle your answer) | | | | |
| Poor | Unsatisfactory | Satisfactory | Good | Very Good |
| List any specific health problems you are currently experiencing: | | | | |
|  | | | | |
| How would you rate your current sleeping habits? \* (Circle your answer) | | | | |
| Poor | Unsatisfactory | Satisfactory | Good | Very Good |
| List any specific sleep problems you are currently experiencing: | | | | |
|  | | | | |
| How many times per week do you generally exercise? \* (Circle your answer) | | | | |
| None | 1-2 Days | 3-4 Days | 4-5 Days | 6-7 Days |
| What types of exercise do you participate in? | | | | |
|  | | | | |
| How often do you drink alcohol? \* (Circle your answer) | | | | |
| Daily | Weekly | Monthly | Infrequently | Never |
| Do you engage in recreational drug use? \* (Circle your answer) | | | | |
| Daily | Weekly | Monthly | Infrequently | Never |
| If Applicable, What kinds of drugs do you use? | | | | |
|  | | | | |
|  | | | | |
| Are you currently experiencing difficulties with your appetite or eating problems? \* (Circle your answer) | | | YES | NO |
| If Yes, How long have you been experiencing appetite or eating problems? Briefly describe. | | | | |
|  | | | | |
|  | | | | |
| Are you currently experiencing difficulties with your appetite or eating problems? \* (Circle your answer) | | | YES | NO |
| If Yes, Approximately how long have you been experiencing sadness? Briefly describe. | | | | |
|  | | | | |
|  | | | | |
| Are you currently experiencing anxiety, panic attacks or have any phobias? \* (Circle your answer) | | | YES | NO |
| If Yes, When did you begin experiencing anxiety, panic attacks or phobia? Briefly describe. | | | | |
|  | | | | |
|  | | | | |
| Are you currently experiencing chronic pain or illness? \* (Circle your answer) | | | YES | NO |
| If Yes, How long have you been experiencing pain or illness? Briefly describe. | | | | |
|  | | | | |
| What significant life changes or stressful events have you experienced recently? \* | | | | |
|  | | | | |

**FAMILY HEALTH HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| In the section below, identify if there is a family history of any of the following: \* (Circle your answer) | | | If Yes, Whom |
| Alcohol/Substance Abuse | YES | NO |  |
|  |  |  | If Yes, Whom |
| Anxiety | YES | NO |  |
|  |  | | If Yes, Whom |
| Depression | YES | NO |  |
|  |  | | If Yes, Whom |
| Domestic Violence | YES | NO |  |
|  |  | | If Yes, Whom |
| Eating Disorders / Obesity | YES | NO |  |
|  |  | | If Yes, Whom |
| Obsessive Compulsive Behavior | YES | NO |  |
|  |  | | If Yes, Whom |
| Schizophrenia | YES | NO |  |
|  |  | | If Yes, Whom |
| Suicide Attempts | YES | NO |  |
|  |  | | If Yes, Whom |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES | NO |  |
| Briefly describe your family mental health history, and the relationship to you. | | | |
|  | | | |
| In the section below, please list your closest relationships. (Circle your answer) | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | Relationship |  | Age |  | Do they live with you? | |
|  |  |  |  |  |  | YES | NO |
| Name |  | Relationship |  | Age |  | Do they live with you? | |
|  |  |  |  |  |  | YES | NO |
| Name |  | Relationship |  | Age |  | Do they live with you? | |
|  |  |  |  |  |  | YES | NO |
| Name |  | Relationship |  | Age |  | Do they live with you? | |
|  |  |  |  |  |  | YES | NO |

**ADDITIONAL INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Education |  | Occupation |  | Marital Status | |
|  |  |  |  |  | |
|  |  |  |  | (Circle your answer) | |
| Are you currently employed? \* | | |  | YES | NO |
| What is your current employment? |  | Do you enjoy your work? | | | |
|  |  |  | | | |
| Is there anything stressful about your current work? | | | | | |
|  | | | | | |
|  |  |  |  | (Circle your answer) | |
| Are you currently in a romantic relationship? \* | | |  | YES | NO |
| If Yes, How long? |  | Rate your relationship from 1 - 5: | | | |
|  |  |  | | | |
|  |  |  |  | (Circle your answer) | |
| Are you spiritual or religious? | | |  | YES | NO |
| If Yes, describe your faith or belief: |  |  | | | |
|  | | | | | |
| Briefly describe your current living arrangement: | | | | | |
|  | | | | | |
| How can I help? In your own words what brings you here today? \* | | | | | |
|  | | | | | |
| Therapy Goal #1 \* |  | Therapy Goal #2 \* | | | |
|  |  |  | | | |
| Is there anything else you’d like me to know? | | | | | |
|  | | | | | |