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	
Anxiety	YES	NO	
Depression	YES	NO	
Domestic Violence	YES	NO	
Eating Disorders / Obesity	YES	NO	
Obsessive Compulsive Behavior	YES	NO	
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?