new client intake

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Contact Information:

name: _____ age: _____ sex: M F

address: _____

e-mail _____

date of birth: ____/_____/_____

phone: home: _____ OK to call you here? Yes No
work: _____ OK to call you here? Yes No
mobile: _____ OK to call you here? Yes No

emergency contact name: _____
emergency contact phone #: _____

occupation _____ education level _____

ethnicity _____ religion _____ practicing? Yes No

Statement of Need
Please provide a brief description of your reasons for seeking counseling at this time:

How have these concerns evolved over time?

What are your goals for our counseling work?

Symptom Inventory & Treatment History

Please rate the severity of the following symptoms over the last month according to the following rating scale:

0: no difficulty
1: mild
2: moderate
3: severe

_____ Decreased appetite
_____ Increased appetite/eating more
_____ Bingeing and/or purging
_____ Weight change? +/- _____ lbs.
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up
Avg. # hours sleep _____
_____ Decreased sexual desire
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Crying
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Decreased attention span
_____ Inattentive/Distractible
_____ Memory problems: Long-term; short-term
_____ Self-injurious behavior
_____ Thoughts of suicide
_____ Thoughts of harming others
_____ Flashbacks of traumatic event
_____ Impulsivity
_____ Nightmares
_____ Hyper vigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heart beat
_____ Trouble breathing
_____ Sweating
_____ Phobia
_____ Police/Probation involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent behavior towards others
_____ Destruction of property
_____ Harming animals
_____ Fire setting
_____ Opposition
_____ Anger outbursts
_____ Irritability
_____ Hyperactivity
_____ Anxiety/Nervousness
_____ Worry/Fear

How many alcoholic beverages do you consume per week? _____

List street drugs used in last 2 months (type/frequency/amount): _____

_____

Family history of substance abuse problems? _____

_____

Previous psychological or psychiatric treatment? (List dates & provider names): _____

_____

_____

Any psychiatric hospitalizations? _____

_____

Medical history: _____

_____

_____

Current medications & dosages: _____

_____

Name of prescribing physician: _____

Current stressors: _____

_____

Have you ever attempted or considered suicide? Y / N (If yes, please provide some detail):
_____

_____

Any other information you would like your therapist to know? _____

_____

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