NEW PATIENT INTAKE FORM

Date _______________

INSTRUCTIONS: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

GENERAL CLIENT INFORMATION

Name**:** (First, Last) ____Gender: ________ Age: ______

DOB: ___________ Address _______________________________________ City: _______________

State: ______ Zip code: ___________ Home Phone: _____________________

Work Phone: __________________ Cell Phone: ______________________

May I leave a Voice Message? ☐ YES ☐ NO

Email address: ____

Emergency Contact:_____________________ Relationship: _______________ Phone: ____________________

Sexual Orientation: ___________________ Ethnic/Cultural Background: __________________

Religion: ______________________ Relationship Status: _________________

Education (highest degree/grade/level):___________________ Occupation: _________________________

Annual Income: __________________ Employer: _______________________________

Referred by: ______________________________

May I thank this referral source for directing you to this practice? ☐ YES ☐ NO

Referral Source Contact Information:

____

CURRENT ISSUES

Please provide a brief description of why you are seeking counseling/therapy services at this time:

Has anything happened that may have brought on/intensified the problems you are experiencing? ☐ YES ☐ NO

If yes, please explain:

When (month/year) did you first begin to experience these problems? ____________________________________

How much is/are the problems affecting you? ☐ Mildly ☐ Moderately ☐ Severely

In what areas do your problems impact your life? (Check all that apply)

☐ Lifestyle (the way you live your life)	☐ Activities (things you normally do or would like to do)
☐ Relationships (your ability to form or maintain relationships with others)	☐ Eating
☐ Sleeping	☐ Mood

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when? __________________

Have you been thinking about suicide? ☐ Yes ☐ No

Have you been thinking about harming or killing someone else? ☐ Yes ☐ No

ADULT PROBLEMS CHECKLIST

Instructions: Please check all that apply to you

☐ Depression	☐ Low energy
☐ Low self-esteem	☐ Poor concentration
☐ Lack of interest/enjoyment in life	☐ Feeling hopeless
☐ Feeling worthless	☐ Feeling guilty or shameful
☐ Sleep changes (more/less)	☐ Loneliness
☐ Bad dreams/nightmares	☐ Feeling ignored or abandoned
☐ Appetite changes (more/less)	☐ Mood swings
☐ Thoughts of hurting self	☐ Thoughts of hurting others
☐ Isolating from others/social withdrawal	☐ Feelings of sadness/loss
☐ Weight problems	☐ Stress
☐ Anxiety/tension/worry	☐ Panic attacks
☐ Heart racing	☐ Chest pain or heaviness
☐ Chills/hot flashes	☐ Tingling/numbness
☐ Pain	☐ Fear of dying
☐ Fear of going “crazy”	☐ Nausea
☐ Fears of phobias	☐ Obsessions/compulsions
☐ Thoughts racing	☐ Disorganization
☐ Procrastination	☐ Can’t hold onto an idea

☐ Anger/frustration	☐ Suspiciousness or mistrustfulness
☐ Problems trusting others	☐ Easily irritated/annoyed
☐ Aggressiveness	☐ Perfectionist behavior
☐ Lying	☐ Making/keeping friends
☐ Arguing with others	☐ Performing unusual rituals or habits
☐ Impulsiveness	☐ Excessive behaviors (e.g., spending, gambling)
☐ Delusions/hallucinations (thinking/believing or seeing/hearing unusual things)	☐ Sexual problems
☐ Self-injurious behaviors	☐ Shyness
☐ Social skills	☐ Social support (family/friends)
☐ Stealing	☐ Strange, weird, or peculiar behavior
☐ Confusion/can't think clearly	☐ Feeling "not real"
☐ Feeling detached from yourself	☐ Feeling "hyper"
☐ Financial problems	☐ Grief/bereavement
☐ Health problems	☐ Impact of your problems on others
☐ Losing track of time	☐ Problems with memory
☐ Unpleasant thoughts that won't go away	☐ Bothered by recurring thoughts
☐ Job/career problems or indecision	☐ Destruction on property
☐ Self-criticism	☐ Family problems
☐ Marital/relationship problems	☐ Parent/child problems
☐ Use of alcohol	☐ Use of drugs

☐ Blackouts	☐ Physical abuse
☐ Sexual abuse	☐ Partner abuse
☐ Trouble with the law	☐ Experienced/witnessed trauma
☐ Loss/death of someone else	☐ Other (please describe): ____

LIVING WITH CHRONIC ILLNESS (Skip to Current Life Experiences if Not Applicable)

☐ I have a chronic Illness ☐ My partner, child, friend, loved one has a chronic illness

What Chronic Illness do you or your partner have? ____

When were you or your partner diagnosed? ___________________________

What physical symptoms do you or your partner deal with from the chronic illness?

____
____
____

How do you or your partner manager these symptoms? (ex: medications, herbal treatments, exercise, acupuncture, etc.)

____
____
____

Does your or your partner's chronic illness affect the ability to take care of oneself (physically, financially, emotionally)? If so, how?

____
____
____

In what ways has the chronic illness affected your relationships?

____
____
____

CURRENT LIFE EXPERIENCES

I live in: ☐ Apartment ☐ House Condo/Townhouse ☐ Mobile Home ☐ Rooming House ☐ Other_______________

I live with:

Name	Age	Relationship to Me	Problems

My sources of satisfaction:

____
____
____

My sources of stress:

____
____
____

My leisure activities:

____
____
____

My current life goals:

____
____
____

What I hope to gain from counseling/therapy:

____
____
____

HISTORY OF COUNSELING/THERAPY

Are you currently being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above? ☐ Yes ☐ No

If yes, please provide the following information:

Date(s)	Name of Professional	Address	Treatment Type (e.g., counseling, therapy, medication, etc)

Please provide information regarding previous treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional	Address	Treatment Type and Reason for Ending

Have you ever been hospitalized for treatment of an emotional or mental disorder? Yes No If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization

MEDICAL HISTORY

Please complete the information below regarding **past and current** medical conditions and treatment:

Date(s)	Physician Name	Address	Condition	Treatment Results

Please list all **current** prescription and over the counter medication use:

Start Date	Medication	Dose	Frequency of Use	Condition Treated

Please list any **previous** prescription and over the counter medication use significant to your counseling/therapy:

Start Date	End Date	Medication	Dose	Frequency of use	Condition Treated

Please list any current or previous use of street drugs, tobacco products, or alcohol:

Start Date	Type Used	Frequency of Use	Amount Typically Used	End Date (if applicable)

Is there anything else you think it would be important for me to know:

____

____

____

____

PLEASE CAREFULLY READ THE STATEMENT BELOW: I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the fee policies, and the No Show/Cancellation Policy. I also acknowledge I have read the Consent for Treatment form and the Notice of Privacy Practices for Protected Health Information. By signing this document, I indicate that I have reviewed, understand, and agree to comply with the policies in this disclosure statement/agreement, and that I consent to treatment for myself or my child.

____

Name (Print) Name (Signature) Date

____

Name (Print) Name (Signature) Date

____

Name of Minor (Print) Name (Signature) Date