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New Client Confidential Intake Form

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**GENERAL INFORMATION**

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Full name: \_\_\_\_\_ Name you prefer: \_\_\_\_\_

Sex:  Male  Female Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnicity:  White  Black  Hispanic  Asian  Other: \_\_\_\_\_

Street address: \_\_\_\_\_ Suite/Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

May we send mail here:  Yes  No

Mailing address or Post Office Box:  Same as above

Street address: \_\_\_\_\_ Suite/Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

May we send mail here:  Yes  No

Home Phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Work phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Cell phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Email: \_\_\_\_\_ Contact you here?  Yes  No

Employer: \_\_\_\_\_ How long have you been there: \_\_\_\_\_

Occupation: \_\_\_\_\_ Average hours worked per week: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_ Are you currently in school?  Yes  No

If Yes, what level? \_\_\_\_\_ Degree pursuing: \_\_\_\_\_

Do you regularly attend a place of worship?  Yes  No. If Yes, where? \_\_\_\_\_

In case of emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**RELATIONAL INFORMATION**

Current marital status:  Single  Dating  Engaged  Married  Separated  Divorced  Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long? \_\_\_\_\_

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Number of previous marriages for you? \_\_\_\_\_ For your partner/spouse? \_\_\_\_\_

Partner's/Spouse's name: \_\_\_\_\_ Partner's/Spouse's age: \_\_\_\_\_

Is your partner/spouse supportive of you seeking counseling?  Yes  No  Unsure  He/She doesn't know

With whom do you currently live? (*Check all that apply*)

Alone  Spouse  Children  Parent(s)  Sibling(s)  Boyfriend  Girlfriend  Roommate  
 Other: \_\_\_\_\_

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption?  Yes  No. If Yes, when? \_\_\_\_\_

Have you ever had a miscarriage or medical abortion?  Yes  No. If Yes, when? \_\_\_\_\_

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

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**COUNSELING HISTORY**

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary)*

Therapist's name or program	Major issue	Dates

**MEDICAL HISTORY**

List any medical conditions, illnesses, treatments, or surgeries:

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Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_

How has your weight changed in the last 2-3 months:  little or no change     up \_\_\_\_\_ lbs.     down \_\_\_\_\_ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts?  Yes  No

Have you experienced them in the past?  Yes  No

Have you ever attempted suicide?  Yes  No

If Yes, when and how: \_\_\_\_\_

Have any of your friends or family ever committed or attempted suicide?  Yes  No

If Yes, when and who: \_\_\_\_\_

Are you presently experiencing any thoughts of harming other person?  Yes  No

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**PRESENT ISSUES**

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past	Present	Past	Present	Past
<input type="checkbox"/>	<input type="checkbox"/> Stress	<input type="checkbox"/>	<input type="checkbox"/> Fears	<input type="checkbox"/>	<input type="checkbox"/> Controlled by others
<input type="checkbox"/>	<input type="checkbox"/> Anxiety or worry	<input type="checkbox"/>	<input type="checkbox"/> Shyness	<input type="checkbox"/>	<input type="checkbox"/> Obsessive thoughts
<input type="checkbox"/>	<input type="checkbox"/> Panic	<input type="checkbox"/>	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/> Compulsive behaviors
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Don't like myself	<input type="checkbox"/>	<input type="checkbox"/> Seeing things others don't see
<input type="checkbox"/>	<input type="checkbox"/> Crying all the time	<input type="checkbox"/>	<input type="checkbox"/> Marital problems	<input type="checkbox"/>	<input type="checkbox"/> Hearing voices
<input type="checkbox"/>	<input type="checkbox"/> Lack of motivation	<input type="checkbox"/>	<input type="checkbox"/> Other relational problems	<input type="checkbox"/>	<input type="checkbox"/> Racing thoughts
<input type="checkbox"/>	<input type="checkbox"/> Fatigue/Lack of energy	<input type="checkbox"/>	<input type="checkbox"/> Parenting problems	<input type="checkbox"/>	<input type="checkbox"/> Eating problems
<input type="checkbox"/>	<input type="checkbox"/> Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/> Physical abuse	<input type="checkbox"/>	<input type="checkbox"/> Drug use
<input type="checkbox"/>	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/> Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/> Alcohol use
<input type="checkbox"/>	<input type="checkbox"/> Poor concentration	<input type="checkbox"/>	<input type="checkbox"/> Verbal abuse	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Feeling worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/> Abortion
<input type="checkbox"/>	<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/>	<input type="checkbox"/> Sexual problems	<input type="checkbox"/>	<input type="checkbox"/> Legal matters
<input type="checkbox"/>	<input type="checkbox"/> Guilt	<input type="checkbox"/>	<input type="checkbox"/> Gender identity	<input type="checkbox"/>	<input type="checkbox"/> Work stress
<input type="checkbox"/>	<input type="checkbox"/> Death of friend or loved one	<input type="checkbox"/>	<input type="checkbox"/> Anger	<input type="checkbox"/>	<input type="checkbox"/> Career choices
<input type="checkbox"/>	<input type="checkbox"/> Grief	<input type="checkbox"/>	<input type="checkbox"/> Aggressive behavior	<input type="checkbox"/>	<input type="checkbox"/> Indecisiveness
<input type="checkbox"/>	<input type="checkbox"/> Chronic pain	<input type="checkbox"/>	<input type="checkbox"/> Bad dreams	<input type="checkbox"/>	<input type="checkbox"/> Lack of discipline
<input type="checkbox"/>	<input type="checkbox"/> Physical disability	<input type="checkbox"/>	<input type="checkbox"/> Unwanted memories	<input type="checkbox"/>	<input type="checkbox"/> Financial problems
<input type="checkbox"/>	<input type="checkbox"/> Terminal illness	<input type="checkbox"/>	<input type="checkbox"/> Loss of control	<input type="checkbox"/>	<input type="checkbox"/> Spiritual apathy
<input type="checkbox"/>	<input type="checkbox"/> Health concerns	<input type="checkbox"/>	<input type="checkbox"/> Impulsive behavior	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Loneliness	<input type="checkbox"/>	<input type="checkbox"/> Controlling		

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Minimally Distressing	Moderately Distressing	Extremely Distressing
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Please describe why you are coming to counseling (*i.e.*, *What are your issues, problems?*): \_\_\_\_\_

Why have you decided to come for counseling now? \_\_\_\_\_

What do you hope to gain or change by coming for counseling? \_\_\_\_\_

**TERMS OF SERVICE**

*I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_