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NEW CLIENT INTAKE FORM - ADULT, COUPLE, FAMILY

Today's Date: _____

If filling this out from website: Please fill out this form and email to the above email address. I will call you within two business days once received to have an over-the-phone consultation and set up an appointment.

General Information:

Client Name _____ Birthdate _____ Age _____

Client Address _____

Client phone# _____

Client email _____

Spouses Name _____ Spouse's Number _____

Emergency Contact Name _____ Number () _____ - _____

Therapy Desired (select all that apply):

Individual

Marital/Couples

Family

Pre-Marital

Financial Information: The fee for a 50-minute session is \$140.00. Hour and a half session are available for \$210.00.

Counseling Information:

Please describe briefly what brings you to therapy

Describe what goal(s) you have in mind for your therapy

Target Symptoms

Thank you for being open about these details. All information will remain confidential.

Please indicate all symptoms that you currently experience by marking the level that best describes their severity. Check on level for each applicable symptom and indicate how long the symptom has been present.

Depressed Mood	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Fatigue/Low Energy	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hopelessness/Helplessness	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Elevated Mood	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Body Complaints	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Suicidal Ideas	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Weight Gain/Loss	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Anxiety	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Lack of Concentration	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Sleep Disturbance	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Panic	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Phobias	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Obsessions/Compulsions	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Impulse Control Issue (Temper)	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Violence, Anti-social Behavior	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Unusual Energy	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Racing Thoughts	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Disorganized Thinking	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Bizarre Ideation/Impulses	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Homicidal Impulses	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Binging/Purging	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Mood Swings	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Irritability	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Delusions	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hallucinations	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Conduct Problems	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Social Isolation	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Worthlessness	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hyperactivity	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Dissociative States	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Aggressive Behavior	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Alcohol/Substance Over Use	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:

Please circle/fill in all that apply.

Marriage Status:		Previous Marriages:		
Single	Yes/No	Yes/No		
Engaged	Yes/No	Number of previous?		
Married	Yes/No	Employment:		
Never married	Yes/No	Employed	Yes/No	
# of prior marriages	Yes/No	Unemployed	Yes/No	
Widowed	Yes/No	Seeking	Yes/No	
Number of Children:		Retired	Yes/No	
Daughters		Substance History:		
Sons		Caffeine	Yes/No	Daily/Weekly/Monthly
Stepdaughters		Alcohol	Yes/No	Daily/Weekly/Monthly
Stepsons		Tobacco	Yes/No	Daily/Weekly/Monthly
Miscarriages	Yes/No	Vape	Yes/No	Daily/Weekly/Monthly
Abortions	Yes/No	Marijuana	Yes/No	Daily/Weekly/Monthly
		Prescription Med	Yes/No	Daily/Weekly/Monthly
Family of Origin:		Other	Yes/No	Daily/Weekly/Monthly
# of Sisters		Treatment History:		
# of Brothers		None	Yes/No	
# of Stepsisters		12-Step	Yes/No	
# of Stepbrothers		Al Anon	Yes/No	
# of Half Sisters		NA	Yes/No	
# of Half Brothers		Inpatient	Yes/No	
Military Service:		Outpatient	Yes/No	
Never	Yes/No	Other	Yes/No	
Currently	Yes/No			
Retired	Yes/No			
Honorably Discharged	Yes/No			
Dishonorable Discharged	Yes/No			

Spiritual Information:

How would you describe your faith/religious upbringing?

Do you presently identify with a certain affiliation/denomination? Yes No I don't know

If so, which one: _____

Do you currently attend a church? Yes o No o Sometimes o If so, where: _____

Medical/Psychiatric History:

Name of Doctor or Psychiatrist: _____

Phone: _____

Are you presently being treated for any health problems? Yes No If yes, please share the health problem(s)

Date of last complete physical exam: _____

Please list all current medications, including dosage, frequency, and reason: _____

Previous psychiatric, emotional, or substance use hospitalization and/or inpatient treatment? This includes any suicide attempts. Yes No o

If yes, please indicate the most recent date, reason, location, and number of occasions. _____

Current Household Members:

Please list household members other than yourself and spouse and state what your relation is to the other members. (i.e., biological child, adopted child, foster child, stepchild, spouse's child, brother, sister, parent, friend, etc.)

Name _____ Relationship _____ Age _____

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Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____