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NEW CLIENT INTAKE FORM –

Today's Date: _____

General Information:

Client Name _____DOB _____ Age _____

Client Address

_____

Client Phone# _____Client Email_____

Spouses Name _____ Spouse's Number_____

Emergency Contact Name _____ Phone#_____

Therapy Desired (select all that apply): Individual Marital/Couples Family Pre-Marital

Financial Information: The fee for a 50-minute session is $165.00. Hour and a half session are $225.00.

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.

Depressed Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Fatigue/Low Energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hopelessness/Helplessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Elevated Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Body Complaints	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Suicidal Ideas	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Weight Gain/Loss	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Anxiety	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Lack of Concentration	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Sleep Disturbance	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Panic	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Phobias	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Obsessions/Compulsions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Impulse Control Issue (Temper)	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Violence, Anti-social Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Unusual Energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Racing Thoughts	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Disorganized Thinking	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Bizarre Ideation/Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Homicidal Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Binging/Purging	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Mood Swings	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Irritability	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:

Delusions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hallucinations	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Conduct Problems	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Social Isolation	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Worthlessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hyperactivity	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Dissociative States	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Aggressive Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Alcohol/Substance Over Use	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:

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 Md or Psychiatrist: _____Phone#: _____

Are you currently 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.

_____

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			

Current Household Members:

Name _____Relationship _____ Age _____

Name _____Relationship _____ Age _____

Name _____Relationship _____ Age _____

Name _____Relationship _____ Age _____

Name _____Relationship _____ Age _____

Name _____Relationship _____ Age _____