NEW CLIENT INTAKE FORM

General Information

Date: | First Name: | MI: | Last Name: | DOB:

Street Address: | City: | State: | ZIP:

Home Phone Number: | Is it OK to leave a message? ☐ Yes ☐ No | SSN:

Cell Phone Number: | Email Address:

Emergency Contact Name: | Emergency Contact Phone Number:

Emergency Contact Relationship:

Referred By:

Family Information

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Number of people currently living in household:

Medical / Psychological History

When was the date of your last medical exam?

Have you ever been treated by a psychiatrist / psychologist / therapist? ☐ Yes ☐ No If so, when?

Do you have a history of: ☐ Depression ☐ Anxiety ☐ Alcohol or Substance Abuse Other:

Are you currently taking any medications for depression, anxiety, or other mood / adjustment disorders? ☐ Yes ☐ No If so, please list:

Please select the following questions to which you would answer "yes."

- ☐ Do you have thoughts of harming yourself or others?
- ☐ Are thoughts of harming yourself or others frequent occurrences?
- ☐ Do you dwell on these thoughts and wonder if you can control them?
- ☐ Have you sought professional help because of these thoughts or feelings?

Please mark the following words that relate to your experience at this time.

☐ Anger	☐ Loneliness	☐ Low Self-Esteem
☐ Anxiety	☐ Hopelessness	☐ Stress
☐ Trauma	☐ Purposeless	☐ Depression
☐ Financial Problems	☐ Marriage Problems	☐ Grief

Other:

What inspired you to seek counseling at this time?

Signature: Date: