New Client Intake Form

Demographic Information

Name: ____ Date: ___________________________

DOB: ______________________ Age: _____________ Gender: _______________________

Birthplace: ____

Street Address: ____

City: ___________________________________ State: _______ Zip Code: _______________________

Phone Number(s): ____
Is it ok to leave a voicemail? *YES* *NO*
Is it ok to send a text message? *YES* *NO*
Email: ____
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How Have We Come to Meet?

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. ____
2. ____
3. ____

Medical & Wellness Information

Have you ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, medications prescribed and results:

____
____
____
____

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Are you presently under a physician's/psychiatrists care? If so, for what reason?

Do you have any allergies (food, environmental, medicinal, animal, etc.)

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

Important Questions We Must Ask

Have you ever had suicidal thoughts/ideations? YES NO
If yes, please explain:

Have you ever planned to hurt yourself? YES NO
If yes, please explain:

Have you ever attempted to hurt yourself? YES NO
If yes, please explain:

Have you ever felt like you wanted to seriously hurt or harm someone else? YES NO
If yes, please explain:

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Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

Are you currently using any illegal drugs, or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

What is your highest level of education completed and field of study?

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Intimate Relationships

If you are currently in a relationship, describe your relationship:

Understanding Your Family & Influences

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

How would you describe your upbringing?

Who lives with you currently?

Describe your relationship with the following:
Mother:

Father:

Mother's Significant Other:

Father's Significant Other:

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Siblings: Age, Name and Sex:

a. Sibling 1 ______________________________

b. Sibling 2 ______________________________

c. Sibling 3 ______________________________

Children:

a. Child 1 ______________________________

b. Child 2 ______________________________

c. Child 3 ______________________________

Significant Other/Spouse: ______________________________

Relationships

Who would you say your support system is (people, organizations, or affiliations)?

____

____

Do you belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

____

How do your religious or spiritual beliefs/practices influence your life?

____

____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

____

____

____

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