

New Client Intake & Consent Form

Therapist: _____

Date _____

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: (Legal/Chosen) _____ Gender: _____ Pronouns: _____ Age: _____ DOB: _____

Address _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May I leave a Voice Message? YES NO

Email address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Sexual Orientation: _____ Ethnic/Cultural Background: _____ Religion:

Relationship Status: _____ Education (highest degree/grade/level): _____

Occupation: _____ Annual Income: _____ Employer: _____

Referred by: _____ May I thank this referral source for directing you to this practice? Yes

No

Contact Info: _____

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:

- Has anything happened that may have brought on/intensified the challenges you are experiencing? Yes No

If yes, please explain: _____

- When (month/year) did you first begin to experience these challenges?

- How much is/are the challenges affecting you? Mildly Moderately Severely

- In what areas do your challenges impact your life? (Check all that apply)
 - Lifestyle (the way you live your life)
 - Activities (things you normally do or would like to do)
 - Relationships (your ability to form or maintain relationships with others)
 - Eating Sleeping Mood
- Have you ever attempted suicide? Yes No If yes, when? _____
- Have you been thinking about suicide? Yes No
- Have you been thinking about harming or killing someone else? Yes No

Challenges Checklist -Please check all that apply to you

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart racing | <input type="checkbox"/> Excessive behaviors
(Examples: spending,
gambling) | <input type="checkbox"/> Losing track of time |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Chest pain or heaviness | <input type="checkbox"/> Delusions/hallucinations
(Thinking/believing or
seeing/hearing unusual
things) | <input type="checkbox"/> Challenges with memory |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Chills/hot flashes | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Unpleasant thoughts that
won't go away |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> Self injurious behaviors | <input type="checkbox"/> Bothered by recurring
thoughts |
| <input type="checkbox"/> Lack of interest/enjoyment
in life | <input type="checkbox"/> Pain | <input type="checkbox"/> Shyness | <input type="checkbox"/> Job/career problems or
indecision |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Social skills | <input type="checkbox"/> Destruction of property |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Fear of going "crazy" | <input type="checkbox"/> Social support
(family/friends) | <input type="checkbox"/> Self-criticism |
| <input type="checkbox"/> Feeling guilty or shameful | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stealing | <input type="checkbox"/> Family challenges |
| <input type="checkbox"/> Sleep changes
(more/less) | <input type="checkbox"/> Fears or phobias | <input type="checkbox"/> Strange, weird, or peculiar
behavior | <input type="checkbox"/> Marital/relationship
problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Obsessions/compulsions | <input type="checkbox"/> Confusion/can't think
clearly | <input type="checkbox"/> Parent/child challenges |
| <input type="checkbox"/> Bad dreams/nightmares | <input type="checkbox"/> Thoughts racing | <input type="checkbox"/> Feeling "not real" | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Feeling Ignored or
abandoned | <input type="checkbox"/> Disorganization | <input type="checkbox"/> Feeling detached from
yourself | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Appetite changes
(more/less) | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Feeling "hyper" | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Can't hold onto an idea | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Thoughts of hurting self | <input type="checkbox"/> Anger/frustration | <input type="checkbox"/> Grief/bereavement | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Suspiciousness or
mistrustfulness | <input type="checkbox"/> Health problems | <input type="checkbox"/> Partner abuse |
| <input type="checkbox"/> Isolating from
others/social withdrawal | <input type="checkbox"/> Problems trusting others | <input type="checkbox"/> Impact of your problems
on others | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Feelings of sadness/loss | <input type="checkbox"/> Easily irritated/annoyed | | <input type="checkbox"/> Experienced/witnessed
trauma |
| <input type="checkbox"/> Weight problems | <input type="checkbox"/> Aggressiveness | | <input type="checkbox"/> Loss/death of someone
close |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Perfectionist behavior | | <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Anxiety/tension/worry | <input type="checkbox"/> Lying | | |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Making/keeping friends | | |
| | <input type="checkbox"/> Arguing with others | | |
| | <input type="checkbox"/> Performing unusual rituals
or habits | | |
| | <input type="checkbox"/> Impulsiveness | | |

Current Life Experiences

- I live in: Apartment House Condo/Townhouse Mobile Home Rooming House Other

- I live with:

Name	Age	Relationship to me	Problems

- My sources of satisfaction: _____
- My sources of stress: _____
- My leisure activities: _____
- My current life goals: _____
- What I hope to gain from counseling/therapy: _____

History of Counseling or /Therapy

- Are you currently being treated by a counselor, psychologist, psychiatrist, and/or other physician for the challenges noted above? Yes No If yes, please provide the following information:

Date(s)	Name of Professional	Address	Treatment Type (counseling, therapy, medication, etc.)

- Please provide information regarding previous treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other challenges:

Date(s)	Name of Professional	Address	Treatment Type	Why treatment ended

- Have you ever been admitted for a psychiatric hospitalization? Yes No
If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization

Medical History

- Please complete the information below regarding past and current medical conditions and treatment:

Date(s)	Physician Name / Address	Condition	Treatment	Results
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- Please list all current prescription and over the counter medication use:

Beginning (date)	Medication	Dose	Frequency of use	Condition Treated
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- Please list any previous prescription and over the counter medication use significant to your counseling/therapy:

Date(s)	Medication	Dose	Frequency of use	Condition Treated
From _____ To _____				
From _____ To _____				
From _____ To _____				
From _____ To _____				

- Please list any current or previous use of non-prescription drug, or alcohol:

Date(s)	Type Used	Frequency of Use	Amount Typically Used	When ended (if applicable)
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- Is there anything else you think would be important for me to know:

PLEASE CAREFULLY READ THE STATEMENT BELOW:

I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the fee policies, and the No Show/Cancellation Policy. I also acknowledge I have read the ***Consent for Treatment*** form and the ***Notice of Privacy Practices for Protected Health Information***. By signing this document, I indicate that I have reviewed, understand, and agree to comply with the policies in this disclosure statement/agreement, and that I consent to treatment for myself or my child.

Name (Print)	Name (Signature)	Date
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Name (Print)	Name (Signature)	Date
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