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New Client Intake Form

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Marital Status (Circle One)			
						Single / Married / Other			
Is this your legal name?	If not, what is your legal name?		(Former Name)		Birth Date		Age	Sex	
<input type="checkbox"/> Yes <input type="checkbox"/> No					/ /			<input type="checkbox"/> M <input type="checkbox"/> F	
Street Address		City	State	ZIP Code	Social Security		Home Phone No.		
					- -		()		
P.O. Box		City	State	ZIP Code			Cell Phone No.		
							()		
Occupation		Employer				Work Phone No.			
						()			
Referred to Provider by (Please check one box & list)				<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Website	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to Home/Work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other _____	
Email Address:					Is it okay to say Don Baker when calling or leaving messages? <input type="checkbox"/> Yes <input type="checkbox"/> No				

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

ADULT INFORMATION

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Phone: _____

Current medications being taken:

1) _____	Dosage/Freq _____	Start Date _____	Purpose _____
2) _____	Dosage/Freq _____	Start Date _____	Purpose _____
3) _____	Dosage/Freq _____	Start Date _____	Purpose _____
4) _____	Dosage/Freq _____	Start Date _____	Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

If no, have you used previously? (Circle One) YES NO

Do you use recreational drugs? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES
NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

(1) How would you describe your current support network? (friends, relatives, etc.): _____

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

Describe your relationship with your mother while growing up:

Currently: _____

Describe your relationship with your father while growing up:

Currently:

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
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<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:

Sexual/physical/emotional abuse:

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? (Circle One) YES NO

Describe:

Describe your current working

environment:

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:

Have you had any change in eating habits? (Circle One) YES NO Describe:

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.)

THOUGHTS: Please check any of the following that apply to you:

___ I sometimes hear voices even though no one nearby is talking to me.

___ I sometimes feel that forces outside of me control me.

___ I sometimes feel that other people control my thoughts.

___ I sometimes have the same thought over and over and cannot control it.

___ I sometimes feel that someone is out to hurt me or do something against me.

___ I am sometimes unable to control my behavior. Please

explain: _____

MARITAL HISTORY

Marital status: ___ Single/never married ___ Married ___ Separated ___ Divorced ___ Widowed ___ Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!