

New Client Intake

To help serve you better, bring this completed form to your first appointment.

DATE (mm/dd/yyyy)			
NAME Legal Name (First, Middle Initial, Last)			
NAME You liked to be called		DATE OF BIRTH (mm/dd/yyyy)	
MAILING ADDRESS	City	State	Zip
PLACE OF BIRTH City	State	Country	
PHONE/EXT Where can I leave a message for you?		EMAIL	

People with whom I can leave a message about your appointments:

NAME First, Last	RELATIONSHIP	PHONE Ext
NAME First, Last	RELATIONSHIP	PHONE Ext

Why did you decide to come to counseling/therapy?

What do you want to work on in counseling/therapy? How long has this been a problem?

Are you currently seeing another mental health therapist? _____ Yes _____ No

If you had prior counseling experience, how would you describe that experience?

Check the symptoms below that are of concern:

- | | | |
|------------------------|----------------------------|--------------------------------|
| Headache | Feel inferior (to others) | Shy |
| Dizziness | Feel tense | Can't make/keep friends |
| Fainting spells | Feel panicky | Afraid of people |
| No appetite | Fears or phobias | Afraid of situations/things |
| Over-eating | Obsessions/compulsions | Issues at home |
| Binge eating | Depressed | Unable to have a good time |
| Stomach trouble | Suicidal thoughts | Always worried about something |
| Bowl disturbances | Prescription drug use | Don't like weekends/vacations |
| Always tired | Recreational drug use | Can't make decisions |
| Always sleepy | Drinking | Over-ambitious |
| Unable to relax | Allergies | Financial issues |
| Insomnia (can't sleep) | Asthma | Gambling |
| Recurrent dreams | Gender questions/issues | Job/school/relationship issues |
| Nightmares | Sexual questions/issues | Can't keep a job/friends |
| Hear voices | Too much/too little energy | Concentration/memory poor |
| Anger, frustration | Spiritual questions/issues | Want more out of life |
| Chronic health issues | Acute health issues | Addiction: _____ |
| Other: _____ | | |
| Other: _____ | | |

Alcohol Consumption

Questions	Never	Monthly or less	2-4 times a month	2-3 times a month	4 or more times a week
1. How often do you have a drink containing alcohol?					
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
3. How often do you have 5 or more drinks on one occasion?					
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
5. How often during the last year have you failed to do what was normally expected of you because of drinking?					
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?					
7. How often during the last year have you had a feeling of guilt or remorse after drinking?					
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?					
9. Have you or someone else been injured because of your drinking?					

Current medications, including prescription, over-the-counter, and herbal

NAME	INDICATION

Last medical examination

DATE (mm/dd/yyyy)	REASON

Are you now under a doctor's care? Yes No

Reason for doctor's care:

Anything else that you want to tell us?

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