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NEW INDIVIDUAL INTAKE FORM
Individual and Couple Clients

If you are scheduled for couple's therapy, you and your partner should individually complete this form; please sign and date where indicated.

Name ____ DOB __/__/___ Age ___________

Gender Pronouns____

Preferred Phone __________________ _ □CellPh □HmPh □WkPh Other: ________________

Preferred Communication: □Cell □Home Phone □Work Phone □Email

Okay to leave a message on my: □ Cell □Home Phone □ Work Phone □ Other __________

Residential Address ___________________________________ City ___________ Zip ______________

May I send mail to this address? Yes No

Email ________________________________May I use email to confirm appointments? Yes No

Employer ________________________________ Type of Work _________________________

Relationship Status: Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact _______________________Relationship_______________Phone_________________

What prompted you to seek therapy?

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Who is impacted by the issue?

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Have you had any prior counseling or psychiatric treatment? ____ No ___Yes
If yes:

When? __________________ Where? ____

Reason for and length of counseling____

Check one: **Therapy was ____ helpful ___ not helpful. Please explain:**

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MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:
____

Date of your last physical exam: ____

Have you been under a physician's care for any reason in the last five years? If yes, please explain.

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PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

For any of the items checked, please provide additional information regarding your symptoms. How often and severe are your symptoms? Do want to share additional information?

____

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PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

For any of the items checked, please provide additional information regarding your symptoms. How often and severe are your symptoms? Do want to share additional information?

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Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse? __Yes __ No

Have you ever felt like you should cut down on alcohol or other drug use? __Yes __ No

Has a friend or relative ever discussed concerns about your drug use? __Yes __ No

Is there a history of problem with alcohol or drug use in your family? __Yes __ No

Have you received help for drug or alcohol dependency? **__Yes __ No**

If yes: When? ________________ Where?______________________________________

Check one: **Treatment was ___ helpful ___ not helpful. Please explain.**

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MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects

Please describe your experience growing up in your family of origin. What was your role? Describe your relationship with your parents and siblings both as a child and currently. What is your birth-order position in the family?

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What stories about you are told in your family?

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What is your role in your current family?

Please describe your medical history.

Please describe your family's medical history.

Please describe your mental health history.

Please describe your family's mental health history.

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Please describe your social behaviors and history of social relationships. Did you make friends easily as a child? Do you struggle with peer relationships?

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Please describe your developmental history. Did you struggle with meeting developmental timelines or a learning difficulty?

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Did you struggle with behavior problems as a child or a teen?

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Have you experienced trauma? If so, please describe.

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What stresses you out and/or upsets you?

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How do you cope with feeling stressed and/or upset?

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Who do you feel supported by?

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What activities do you do for fun?

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What do you do to relax and/or care for yourself?

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Describe your personal strengths.

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Describe your personal challenges.

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If your problem was resolved, how would you know? What would be different?

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If you had three wishes for yourself, what would they be?

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If your three wishes came true, how would you know? What would be different?

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What are your three essential values?

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Describe your goals for therapy:

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Is there anything else you think would be helpful for me to know about you or your situation?

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By signing below, I confirm the information I provided on this document to be complete and truthful to the best of my knowledge.

________________________	______________________________	________
Client Name (please print)	**Client Signature (or authorized representative)**	**Date**