New Client Intake Form

Date____________________ **Intake person**______________________

Client Name____

Date of Birth_____________ **Age**________

Status: Married Single Divorced Widowed Domestic Partner Gender ___________

Parent's name (including step parents____

____

Home Address____

City____ **State**____________

Zip____________________

Preferred phone# Home______________________________ Cell __________________________

Email____

School/grade/teachers name:____

Referred by___________________________________

Does the client have legal guardianship? If so, please provide a copy of guardianship.

Does the client have an Individualized Education Plan (IEP)? If so, please provide a copy.

Insurance: Yes_____ No_____

Insurance Co________________________________ **Policy/Plan name**____________________

Insurance ID#____________________________________ **Group #**________________________

Subscriber_______________________________ **Subscriber date of birth:** _______________

Subscriber employer: _______________________**Relationship to Client** ________________

Customer phone service #__________________________

____

Client information:

Brief description of presenting issues:

____

____

____

____

Is patient under the care of a therapist ______Yes ________NO

Name of therapist ______________________ How long had client been treated _________

Has the patient ever been hospitalized? ___Yes ___ NO - If so where/when____________

Medications: (Name & Dosage)

____

____

Please describe the reason(s) you are seeking counseling at this time:

____

____

____

____

What have you done in the past to manage the reasons you are seeking counseling?

____

____

____

Please describe significant events in family history: (family changes, moves, losses, etc.)

____

____

____

Family history of mental illness? No _____ Yes _____, if yes who, diagnosis other information:____

____

Describe your main strengths:

____

____

Describe your most significant challenges:

____

____

What are hoping to gain or accomplish in treatment:

____

FAMILY INFORMATION

Please list all members of the client's household:

Name	Relationship	DOB	Gender	Occupation/Grade in School

Custody arrangements (if applicable):

____

SYMPTOM CHECKLIST

Review the following symptoms and mark the symptoms you are experiencing:

Physical Symptoms:

___ headaches ___ insomnia ___ excessive sweating ___ muscle ache

___ daytime drowsiness ___ increased appetite ___ stomach aches

___ diarrhea/constipation ___ poor appetite

other____

Behavioral symptoms:

___ increased cigarette use ___cutting ___ low motivation/energy

___ increased alcohol use ___ skin picking ___ excessive energy

___ increased illegal substance use ___ binge eating ___ poor self-care

___ excessive spending ___ impulsive risk taking ___ excessive exercise

___ restricting food intake ___ avoiding social contacts ___ hair pulling

___ poor concentration ___ forgetfulness ___ purging

Other____

Emotional Symptoms:

___ easily frustrated ___ cry easily ___ changing moods ___ anger ___ worried

___ thoughts of suicide ___ feel something bad will happen ___ hopeless

___ thoughts of homicide ___ intrusive/upsetting thoughts ___racing thoughts

___ irritable ___ scared ___ lonely ___ sad

other____

Has your child experienced any of the following problems at school:

___ Emotional ___ poor grade ___ detention ___ Behavior problems

___ fighting ___ lack of friends ___stomach aches ___ poor attendance

___ suspension ___ bullying ___ learning disabilities ___ incomplete homework

other____

Do you currently feel suicidal?__________ Do you have a plan and a means to kill yourself? ________

Do you currently feel homicidal?________ Do you have a plan and a means to kill someone else?______

Other information: