

New Client Intake Form

Name: _____

Address: _____

Phone: Cell _____

Home _____

Work _____

E-mail: _____

Would you like to receive your billing statements via e-mail? Yes ___ No ___

Who were you referred by? _____

If you were self-referred, how did you find me? _____

Emergency Contact: _____

Primary Care Physician: _____

Prescribing Physician: _____

Preferred Pronouns: _____

Date of Birth: _____

Marital Status: Mar Sing Widow Divorce Separated

List ages of any children: _____
Living with partner

-
-
-

General description of what brings you to therapy: _____

I am currently experiencing (check all that apply): Depression ___ Sadness ___ Anxiety ___ Grief ___
Loneliness ___ Anger ___ Lack of Motivation ___ Difficulty in Relationships ___ Work-related Issues ___
Alcohol or Drug Issue ___ Problems with Sleep ___ Problems with Eating ___ Sexuality Issues ___
School-related Issues ___ Medical Issues ___ Suicidal Thoughts _____ r
Spirituality _____ Other _____ Other _____

Abuse Trauma?

Complex Trauma?

Childhood Emotional Neglect? (CEN)

Have you ever seen a therapist before? Y N

If yes, when and what for: _____

Have you ever been prescribed drugs for mental health issues? Y N

If yes, when and what did you take: _____

Do you have any current medical problems? Y N

If yes, please describe: _____

List all current medications with doses: _____

Have you ever been treated for substance abuse? Y N

If yes, when and what for: _____
