



New Client Intake Form

Contact Information

Name _____

Date _____

Date of Birth _____

Cell # _____

Address _____

E-Mail _____

Okay to text? _____

Gender _____

Pronouns _____

Education and Employment Information

Company/School Name _____

Address _____

Title _____

Describe Current Position _____

Highest Grade Completed _____

Current Grade Level _____

Family Information

Closest relative, partner or friend

Name _____

Phone Number _____

In Case of Emergency Call _____

Name and Number if Different From Above

Who do you live with? _____
Parent, Grandparent, Partner, Friend and their Name

Race (Please check all that apply or add to the list)

- | | |
|---|--|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian/Native | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> White | <input type="checkbox"/> You Tell Me _____ |

Please write in the ethnicity, culture, nationality and religions you identify with or were born into below:

Medical and Mental Health Information

Primary Care Physician _____
Name and Number

Other Medical Professionals Used (include contact information)

Any Health Concerns? _____

Any Mental Health Concerns? _____

Please explain any major stressors, life changes or other relevant information about your health and wellness: _____

Military Status, branch, highest rank, how long: _____

Questions below are best answered prior to the first appointment. If there are any questions that do not apply, skip them. If you would prefer to discuss an answer in person, please make a note and we will review this form together at your initial appointment.

Why are you seeking counseling at this time?

Have you had counseling before? When and for how long?

Have you ever been diagnosed with an illness that you think I should know about?

What is your biggest concern in a day or a week?

Do you use alcohol or drugs? Do you use pain medication? How often?

Have you ever been hospitalized for psychiatric illness? If so, please explain.

Have you or someone close to you ever attempted or completed suicide? If so, please explain.

How well are you doing at your job?

How is (are) your relationship(s)? Your friendship(s)?

Please describe what types of food you eat.

How often do you exercise? What forms of exercise do you use or enjoy?

How happy are you?

Check the box on the scale below with 1 being the least happy and 5 being the most happy.

1

2

3

4

5

What is the most relaxing thing you do in a day or week?

What activities do you enjoy doing the most?

What is your biggest strength, skill or talent?

What motivates you at school, work or home?

What helps you the most when you feel down?

Please circle the behaviors, characteristics, symptoms, problems or feelings that have been causing you stress, pain or limiting you in home, school or work:

Sadness	Trembling	Internet	Exercise
Depression	Mood Shifts	Panic	Racism
Anxiety	Fatigue	Self-esteem	Sexism
Fear	Pain	Family	Power
Aggression	Gambling	Relationships	Spiritual Beliefs
Anger	Sex	Work	Homophobia
Antisocial	Loss	Boss	Divorce
Avoiding People	Suicidal Thoughts	Teachers	Death
Disorganized	Loneliness	School	Moving
Impulsive	Recurring Thoughts	Bullying	Health changing
Irritable	Recurring Habits	Being the best	Flashbacks
Moody	Sick Often	Being the worst	PTSD
Communication	Hearing voices	Goal setting	Risk Taking
Strange Thoughts	Speech Problems	Hurting self	Assault
Alcohol Use	Hopelessness	Violence to others	Memory
Drug Use	Food/Eating	Money	Parents

Please use the rest of this page to tell me anything else you would like to share about yourself.