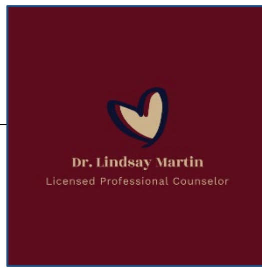

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New Patient Intake Form

Please complete this form and return when completed. All requested forms must be completed and submitted at least 24 hours prior to your first appointment. If you are unable to complete the required forms within that time, we will have to reschedule your appointment. Thank you for taking the time to complete this form. It will help streamline our intake process, allowing us to more quickly address your areas of concern.

General Information

Full Name ____________________
Date of Birth ____________________
Address ____________________
Phone Number ____________________
May I contact you at the phone number above and leave a general message? ☐ Yes ☐ No
Email Address ____________________
May I contact you at the email address above? ☐ Yes ☐ No

Emergency Contact Name ____________________
Emergency Contact Phone Number ____________________

Sexuality/Gender Identity/Relationship/Child History

How do you identify your gender? What pronouns do you use? ____________________
How do you identify your sexuality? ____________________
Current Marital/Relationship Status? ____________________
Do you have any children? ____________________

Current Concerns

In your own words, what brings you to counseling?

____
____
____
____
____

How long have you been feeling this way?

____

____

Are you **currently** experiencing any of the following to the point of negatively impacting your daily life? Please check all that apply.

- ☐ Aggression
- ☐ Anger Outburst
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Avoidance of People
- ☐ Chest Pains
- ☐ Computer Obsession
- ☐ Depression
- ☐ Difficulty Thinking
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Elevated Mood
- ☐ Easily Distracted
- ☐ Fatigue
- ☐ Fears/Phobias
- ☐ Gambling that is Problematic
- ☐ Hallucinations
- ☐ Headaches
- ☐ Helplessness
- ☐ Hopelessness
- ☐ Impulsiveness
- ☐ Indecisiveness
- ☐ Irritability
- ☐ Loneliness
- ☐ Memory Problems
- ☐ Mood Swings
- ☐ Muscle Tension
- ☐ Obesity
- ☐ Panic Attacks
- ☐ Racing Thoughts
- ☐ Sexual Obsessions
- ☐ Sexual Difficulties
- ☐ Sleep Problems
- ☐ Stress
- ☐ Suicidal Thoughts
- ☐ Trembling/Shaking
- ☐ Weight Gain (Non-intentional)
- ☐ Weight Loss (Non-intentional)
- ☐ Withdrawn Socially
- ☐ Worrying
- ☐ Worthlessness
- ☐ Other ___________________________
- ☐ Other ___________________________

Is there anything that you can identify that might be causing these feelings to occur?

____

____

____

Are you **currently** experiencing of the following?

- ☐ None
- ☐ Thoughts of hurting self
- ☐ Thoughts of suicide
- ☐ Not wanting to wake up, or that something bad will happen to you outside your control
- ☐ Plans to complete suicide
- ☐ Made threats to kill self
- ☐ Self-harm/Mutilation
- ☐ Thoughts of seriously harming someone
- ☐ Plans to harm someone
- ☐ Attempted to harm someone

☐ Made threats to harm someone
☐ Other: ____

Mental Health History

Have you ever been diagnosed with a mental health condition in your lifetime? If yes, please name.
____
____

Have you ever been engaged in any of the following types of care?

☐ Therapy/Counseling
☐ Intensive Outpatient/Partial Hospitalization
☐ Residential Inpatient Psychiatric Hospital
☐ Medication Management
☐ Case Management
☐ None

If you have a history of treatment, please add additional details about when, how long, the general concern that was addressed, and other important details surrounding your treatment history.
____
____
____

Have you **ever** experienced any of the following?

☐ Thoughts of hurting self
☐ Thoughts of suicide
☐ Not wanting to wake up, or that something bad will happen to you outside your control
☐ Plan to commit suicide
☐ Made threats to kill self
☐ Self-harm/Mutilation
☐ Thoughts of seriously harming someone
☐ Plans to harm someone
☐ Attempted to harm someone
☐ Made threats to harm someone
☐ Other: ____
☐ None of the above

Abuse/Neglect/Exploitation Assessment

History of Neglect

Please check off any of these answers that apply to you.
☐ As a child, you had no one emotionally present for you
☐ As a child, you did not have enough food, or there was food but you were not allowed to eat it
☐ As a child, you were not taken to the doctor when you needed to be seen
☐ As a child, you were not allowed to go to school
☐ Never experienced neglect as a child

Please provide additional information if comfortable.

____
____
____

History of Abuse

Have you experienced a history of abuse? Please check off any of these answers that apply to you.

☐ Physical
☐ Emotional
☐ Sexual
☐ Domestic Violence
☐ Other
☐ Never experienced abuse

If you experienced abuse, was it ever reported? ☐ Yes ☐ No ☐ NA

If you have experienced a history of abuse, please provide additional information, if comfortable.

____
____
____

Childhood Experiences

Where were you born and raised? ____
Who raised you? ____

Overall, I would describe by childhood as:

☐ Good. Overall, I had a positive childhood
☐ Overall good, but there were sometimes difficulties
☐ Average, not great but not terrible
☐ Negative
☐ Horrible, chaotic, unsafe, dangerous

Any additional childhood details? You can be as brief or as detailed as you wish.

____
____
____
____

Family History of Substance Abuse and Mental Health Issues

Please identify if any family member, including your mother, father, siblings, mother's side of the family, father's side of the family, or your own children have a substance abuse or mental health history. If you believe a family member has a concern but do not know for sure, identify it with a '?' after their relationship to you.

☐ Alcohol Abuse: ____
☐ Substance Abuse: ____

☐ Died by Suicide: ____
☐ Committed Homicide: ____
☐ ADHD/ADD: ____
☐ Anxiety: ____
☐ Bipolar: ____
☐ Depression: ____
☐ Psychosis (or other psychotic disorder): ____
☐ Personality Disorder: ____
☐ Attempted Suicide: ____
☐ Psych Hospitalized:____
☐ Long Term Incarcerated:____
☐ Other ____
☐ No Family History of Mental Health or Substance Use/ Abuse Problems

Personal Substance Use/ Abuse History

Have you ever abused any of the following substances?
☐ Alcohol
☐ Any Tobacco Use
☐ Marijuana
☐ Cocaine/Crack
☐ Heroin
☐ Amphetamines
☐ LSD/Hallucinogens
☐ Ecstasy/Molly
☐ Inhalants
☐ Prescription Pain Pills
☐ Prescription benzodiazepines/“downers”
☐ Other:_____________________________________
☐ I have never had problematic alcohol, tobacco, or drug use

Consequences due to Drug/Alcohol Use/Abuse

Please identify any consequences you have had due to drug/alcohol use or abuse:

☐ No History of Consequences related to Alcohol/Drug Abuse
☐ Assaults
☐ Arrests
☐ Binges
☐ Blackouts
☐ Custody Problems
☐ DUI
☐ Divorce/Family Problems
☐ Hangovers
☐ Increased time spent obtaining/using drugs/alcohol
☐ Increase Tolerance
☐ Incarceration
☐ Medical Problems
☐ Overdose
☐ Relationship Problems
☐ Shakes
☐ Seizures (DTs)
☐ Sleep Problems

History of Alcohol or Substance Abuse Treatment

Please identify any treatment you have received for a drug or alcohol problem.

☐ Detoxification
☐ Therapy/Counseling
☐ Group Therapy
☐ AA/NA
☐ Drug Court
☐ Intensive Outpatient or Partial Hospitalization
☐ Residential
☐ Sober Living Community
☐ Other:___________________________________
☐ No History of Drug or Alcohol Abuse Treatment

If currently not in sobriety but working towards sobriety, what is the longest period of sobriety in your lifetime? ____
If sober from alcohol and drugs, how long have you been sober? _________________________________

History of Eating Disorder(s)

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Please check any eating disorder treatment you have received.
☐ Outpatient Therapy
☐ Outpatient Nutritional Support
☐ Weight Supervision by Medical Professional for Eating Disorder
☐ Group Therapy
☐ IOP/PHP
☐ Residential
☐ Hospitalized for ED Related Concerns
☐ No Reported Eating Disorder Treatment

Problematic Gambling Behaviors

Please check any of the following that apply to you.
☐ Gambled longer than planned
☐ Lost sleep thinking of gambling
☐ Been remorseful for gambling
☐ Asked others for money to gamble
☐ Gambled until last dollar spent
☐ Made repeated unsuccessful attempts to stop gambling
☐ Broke the law or thought about breaking the law to obtain money for gambling
☐ Gambled to get money for financial obligations (rent, mortgage, utility bill, etc.)
☐ I do not have any problematic gambling behaviors

Current or Past Legal Involvement

Please check all that apply.

☐ I have no legal history
☐ Arrests
☐ Convictions
☐ DUI
☐ Gangs
☐ Jail/Prison
☐ Juvenile Legal History
☐ Probation/Parole
☐ Other:___________________________

Please add clarifying information, if comfortable.

____
____

Medical & Physical Health

Do you have any known drug allergies? ☐ Yes ☐ No
If yes, explain: ____

Please identify any current medical problems, including medical problems you may not currently be receiving treatment for (such as type II diabetes or high cholesterol controlled through diet/exercise).

____
____
____

Hospitalization/Surgery History

Please identify any significant hospitalization or surgeries you have had in your lifetime

____
____
____

Current Medications

Are you currently taking any medication? If yes, please list.

____
____
____

Current Pain

Are you currently experiencing pain? Including chronic, widespread pain. If yes, please explain.

____
____

Are you able to care for yourself? ☐ Yes ☐ No ☐ With assistance

Do you use any assistance or adaptive devices such as a cane, walker, brace, wheelchair, crutches, artificial limb, etc.? If yes, please list.

____
____

Housing & Support

Who do you get emotional support from?
This could be someone you call if you need help or want to talk to someone about a problem.

☐ Immediate Family
☐ Extended Family
☐ Friends
☐ Co-workers
☐ Schoolmates
☐ Religious Community
☐ Other: ____

Please identify your current living situation.

☐ Housing Adequate
☐ Living with Friends
☐ Living with Family
☐ Living with Roommates
☐ Living in College Housing
☐ Housing is Dangerous
☐ Housing is Overcrowded
☐ Homeless
☐ Other: ____

Who lives with you in your home?
(Names are not needed. Please identify relationship to you. Ex. husband, son, mother, uncle, etc.)

____
____
____

Education & Employment

What is the highest level of education you've obtained?

☐ Less than High School
☐ High School Diploma
☐ GED
☐ Technical College
☐ Community College/Junior College/AA
☐ Some College
☐ Bachelor's Degree
☐ Master's Degree
☐ PhD
☐ MD/JD
☐ Other: _______________________

Are you currently attending a school/college? ☐ Yes ☐ No

Were you ever in special education classes while in school? Or have you had any other educational support (ESL, extensive tutoring for a learning disability, IEP) for any reason. If yes, please explain.

____
____

Are you currently employed? ☐ Yes ☐ No
If yes, please explain the type of work you do. ____

Are you happy at your current job or employment status? ☐ Yes ☐ No

Source of Income

Please identify any source of income that you have.
☐ Employment Income
☐ Disability Income
☐ Military Income
☐ Retirement Income
☐ Spouse/Partner Income
☐ Child support/Alimony
☐ Financial Aid
☐ Unemployment
☐Other:____

Military History

Have you ever been involved with the military for any reason?

Self	☐ No	☐ Yes	☐ Current	☐ Past
Significant other	☐ No	☐ Yes	☐ Current	☐ Past
Family member(s)	☐ No	☐ Yes	☐ Current	☐ Past

Spiritual/ Religious Information

How do you describe your spirituality?
☐ Atheist
☐ Agnostic
☐ Religious
☐ Spiritual
☐ Moral
☐ Other: ____

Is there a religious community (organized or not) you feel connected with?
☐ Yes, Christian
☐ Yes, Jewish
☐ Yes, Muslim
☐ Yes, Hindu
☐ Yes, Pagan/Neo-Pagan
☐ Yes, Other: ____
☐ No

Acknowledgement

I confirm that the answers I have provided are my current truth and have been completed to the best of my ability.

Print Name ____

Signature ____

Date ____