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New Client Intake Form

These questions are intended to help me gather information to better understand you and make the most of our time together. Please complete all sections that apply to you. You may spend as much time on this as feels right. All information is kept confidential.

Name: _____ Pronouns: _____
Birth Date: _____/_____/_____ Age: _____ Date of first appointment: _____/___/_____

Referred by: □ Google Search - searched for: _____

□ Psychology Today □ OnlineTherapy.com □ Zencare □ GoodTherapy □ TherapyDen □ CAMFT

□ Medical/Health Practitioner: _____

□ Friend/Family: _____ □ Other: _____

Contact Info:

Address: _____ (Street and Number)
_____ (City, State, Zip)
Home Phone: _____ May I leave a message? □ Yes □ No
Cell/Other: _____ May I leave a message? □ Yes □ No
E-mail: _____ May I email you? □ Yes □ No
Would you like to be added to my mailing list to receive updates, mental health tips, and resources? □ Yes □ No

Emergency Contact:

Name: _____ Relationship: _____
Phone number: _____
Do you give permission to contact this person in case of an emergency? □ Yes □ No

Occupation Info:

Occupation: _____ Place of Employment: _____
Work number: _____ If needed, is it ok to call here? □ Yes □ No

Mental Health History & Current Challenges:

Have you previously received any type of mental health services? □ No □ Yes
If yes, which of the following:
□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization
Name of Provider(s), or Facility (if hospitalized): _____
_____
Contact info of Provider(s): _____
Dates of Treatment: _____
Reason for Treatment: _____

Briefly, what brings you in today? _____

_____

_____

When did this first start? Within the last:
□ 30 days □ 3-6 months □ 6-12 months □ 2 years □ During age: _____

How has this impacted your life? _____

_____

What would you like out of our time in therapy? _____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced: _____

_____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

Family History:

Cultural Background/Identity: _____
Where were you born? _____ Where did you grow up? _____

Please list your parents and siblings:

Name _____ Age ____ Relationship _____

Name _____ Age ____ Relationship _____

Name _____ Age ____ Relationship _____

Name _____ Age ____ Relationship _____

Name _____ Age ____ Relationship _____

Where do they now live? _____

If deceased, include age and cause of death: _____
Are/were your parents □ Married □ Separated □ Divorced If divorced, when? _____
Who did you live with growing up? _____
Parent 1 (specify) occupation: _____ Parent 2 (specify) occupation: _____

In the section below identify if there is a family history of any of the following conditions (if yes, please specify the family member's relationship to you in the space provided (father, grandmother, uncle, etc.):

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Sexual Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Other mental health condition?	yes/no : which was —	_____

Relationship Status:

Gender Identity: _____ Sexual orientation: _____

Are you currently in a romantic relationship? □ No □ Yes - If Yes: - For how long? _____

What's your partner(s)'s name? _____

Relationship structure: □ Monogomous □ Non-monogomous □ Polyamorous □ Other_____

On a scale of 1-10, how would you rate your relationship? _____

Marital Status: □ Never Married □ Domestic Partner □ Currently Married- for how long? _____

□ Separated □ Divorced □ Widowed- If widowed, please give partner(s) name(s), year deceased, and cause of death: _____

Please list any children, their names, and ages:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name of other parent _____ If deceased, age and cause of death _____

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication name	Dosage	Condition	Began/Stopped date

Prescribing provider and contact information: Name & License: _____
Facility: _____ Phone and/or email: _____

On a scale of 1-10, how would you rate your sleep? _____ Why? _____

_____

How do you exercise and how often: _____

_____

Any change in weight over the past year? □ No □ Yes - please elaborate: _____

_____

Please list any difficulties you experience with your appetite, or eating patterns: _____

_____

Are you currently experiencing any chronic pain? □ No □ Yes - If yes, please describe: _____

_____

Please describe *current and previous* use of alcohol, marijuana, and/or other recreational drugs, including frequency & amount: _____

_____

_____

***Do you agree to not use alcohol, marijuana, and other recreational drugs for 12 hours before a session?**
□ No □ Yes If no, please share why _____

_____

Strengths & Additional Info:

What do you enjoy about your current or previous work (full-time homemaker included)? _____

_____

What do you find particularly stressful about your current or previous work? _____

_____

_____

How do you relax? _____

_____

What are you values? _____

_____

What brings you joy? _____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief: _____

_____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your growth edges? _____

_____

_____