NEW CLIENT INTAKE FORM

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Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

Medical Provider: _____

Insurance Provider: _____

Baskincounseling.com/PsychologyToday/TherapyDen/Good Therapy

Friend/Family: _____

Other: _____

Have you previously received any type of mental health services? Yes__ NO__

If yes, which of the following: Psychotherapy __ Medication __ Outpatient Hospitalizations __

Inpatient Hospitalizations __

If yes, please provide:

Name of provider or facility:_____
Location:_____

Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today: _____
_____

When did your problem first start? Within the last: 30 days __ 6–12 months __ 1–2 years __ 2+ Years __

During adolescence __ During childhood __

What areas of your life have been affected because of this problem (family, work, relationships, etc)? ___
_____

Are you currently experiencing overwhelming sadness, grief or depression? Yes__ No __ Unsure __

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes__ No __ Unsure __

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? _____
_____
_____

What would you like to accomplish out of your time in therapy?_____
_____
_____

Family History

Where were you born? _____ Where did you grow up?_____

I lived in the following setting: Urban(City) / Suburbs / Rural (Country)

Please list your parents and siblings. Please use additional space on the back if needed:

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate 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 Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	(specify condition)	

Marital Status: Never Married __ Domestic Partner __ Married __ Separated __
Divorced __-- how long?_____ Widowed __ Please provide your partners name and year deceased:_____

If married, how long have you been married for and what is your partners name: _____
_____

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

Are you currently in a romantic relationship? Yes__ How long? _____ No __

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

Please list any children, their names, and ages:

Name	Age	Relationship	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. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

How would you rate your current physical health?

Poor __ Unsatisfactory __ Satisfactory __ Good __ Very Good __

Please list any specific health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits?

Poor __ Unsatisfactory __ Satisfactory __ Good __ Very Good __

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep __ Staying asleep __ Awakening early __ Sleep apnea __

Please list any other specific sleep problems you are currently experiencing: _____
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

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

Please describe current use of alcohol, cigarettes, and/or recreational drugs:_____
_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs: _____
_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work? _____
_____

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

What do you enjoy doing in your free time? What do you do to relax? _____
_____

Do you consider yourself to be spiritual or religious? If yes, please 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 areas? _____
_____