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NEW CLIENT INTAKE FORM

Date: ____ / ____ / _____

BASIC INFORMATION

Name: dfdfdf _____

Gender: ☐ male ☐ female Age: _____ Date of birth: ____ / ____ / _____

Preferred phone: _____ ☐ cell ☐ home ☐ work ☐ other

Permission to leave detailed messages on this phone? ☐ yes ☐ no

Alternate phone: _____ ☐ cell ☐ home ☐ work ☐ other

Permission to leave detailed messages on this phone? ☐ yes ☐ no

Mailing address: cvcvx _____

Street address, if different: _____

Email address: dfdfdfdfdfdf _____

Current occupation: _____

Employer: _____

Relationship status:

☐ single ☐ married / partner ☐ separated ☐ divorced ☐ widowed

Emergency contact: _____ Relationship: _____

Phone: _____

Referred by: _____ Phone: _____

Current therapist: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

May we exchange information with your treating clinicians to coordinate your care?

Therapist: ☐ yes ☐ no PCP: ☐ yes ☐ no

Pharmacy: _____ Phone: _____

Address: _____

Person responsible for payment, if other than client: _____

Relationship: _____ Phone: _____

Address: _____

PRIOR PSYCHIATRIC HISTORY

Have you ever been diagnosed with a mental illness? ☐ yes ☐ no

If yes, please specify the diagnosis or diagnoses you have been given:

_____

_____

_____

Do you feel the diagnosis is accurate? ☐ yes ☐ no ☐ not sure

Have you received outpatient psychiatric treatment in the past? ☐ yes ☐ no

If yes, when was your last appointment (approximately)? _____

Have you ever been admitted to an inpatient psychiatric unit? ☐ yes ☐ no

If yes, how many times? _____

At which hospital(s) were you admitted? _____

_____

_____

When was your most recent hospitalization (approximately)? _____

What was the main reason for that hospitalization? _____

Have you ever attempted suicide? ☐ yes ☐ no

If so, when and how? _____

Please list any psychiatric medications you have taken in the past, and indicate if any were especially helpful or caused problems:

_____

_____

_____

_____

Have you ever received treatment for substance abuse or other addictions? ☐ yes ☐ no

If yes, please specify: _____

_____

_____

_____

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times per month

☐ 2-3 times per week ☐ 4 or more times per week

How many drinks do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Any history of withdrawal symptoms from not drinking (e.g., tremors, seizures)? ☐ yes ☐ no

Has alcohol ever caused problems for you? ☐ yes ☐ no

If yes, please specify: _____

_____

How many caffeinated beverages (coffee, soda, etc.) do you drink on an average day? _____

Do you or have you ever smoked? ☐ yes ☐ no

Packs per day: _____ Years smoked: _____ Date quit: _____

Have you ever used any of the following recreationally?

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Ecstasy / Molly ☐ LSD ☐ Mushrooms

☐ Speed ☐ PCP ☐ Ketamine ☐ Opiates (e.g., Oxycontin, Percocet)

☐ Benzodiazepines (e.g., Xanax, Valium) ☐ Other: _____

Has your use of any of the above caused problems for you? ☐ yes ☐ no

Do you currently use any of these on a regular basis? ☐ yes ☐ no

If so, which one(s)? _____

Why are you seeking help at this time?

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

_____

_____

MEDICAL HISTORY

Previously diagnosed medical conditions:

_____

_____

_____

Any history of head injury? ☐ yes ☐ no

Do you have any allergies? ☐ yes ☐ no

If so, indicate what kind of reaction for each substance or medication:

_____

_____

EDUCATION

Degree(s) earned: _____

Any learning problems in school? ☐ yes ☐ no

Any behavioral or hyperactivity problems at school? ☐ yes ☐ no

FAMILY INFORMATION

	Name	Living with you?	Important Medical History	Age Deceased	Current Age
Spouse or partner					
Children					
Mother					
Father					
Siblings					

Is there anyone else living with you not mentioned above? ☐ yes ☐ no

If so, please indicate name and relationship:

_____

Does or did anyone in your family have psychiatric illness (i.e. depression, anxiety, substance abuse, or other diagnoses)? ☐ yes ☐ no

If so, please specify their relationship(s) and diagnosis:

_____

_____

Do you have difficulties in any of your relationships? ☐ yes ☐ no

If so, please describe:

_____

_____

_____

Medications you are currently taking:

Medication name	Dose	Frequency	Since when?	Has it helped?	Side effects?

SYMPTOM CHECKLIST

Check the column that best describes how often you experience each of the following:

	Never	Rarely	Sometimes	Often
Depressed mood	☐	☐	☐	☐
Difficulty sleeping	☐	☐	☐	☐
Overeating	☐	☐	☐	☐
Decreased appetite	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Low energy	☐	☐	☐	☐
Low self-esteem	☐	☐	☐	☐
Wanting to harm yourself	☐	☐	☐	☐
Harm to self	☐	☐	☐	☐
Premenstrual symptoms	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Unusually high energy	☐	☐	☐	☐
Excessive risk-taking	☐	☐	☐	☐
Difficulty controlling anger	☐	☐	☐	☐
Wanting to harm others	☐	☐	☐	☐
Hearing things not there	☐	☐	☐	☐
Seeing things not there	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Feeling panicked	☐	☐	☐	☐
Intense fears (planes, heights, etc)	☐	☐	☐	☐
Fear of social situations	☐	☐	☐	☐
Fear of leaving the house	☐	☐	☐	☐
Fear of being sick	☐	☐	☐	☐
Fear of dying	☐	☐	☐	☐
Physical pain	☐	☐	☐	☐
Doing or thinking things over and over	☐	☐	☐	☐
Frequent nightmares	☐	☐	☐	☐
Memory problems	☐	☐	☐	☐
Feeling detached from others	☐	☐	☐	☐
Sexual difficulties	☐	☐	☐	☐
Fear of being overweight	☐	☐	☐	☐
Vomiting / purging	☐	☐	☐	☐
Addictive behavior	☐	☐	☐	☐