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NEW CLIENT INTAKE FORM

Date: ____ / ____ / _____

BASIC INFORMATION

Name: _____

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: _____

Street address, if different: _____

Email address: _____

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				