

Name:

Date of Birth:

**NEW CLIENT INTAKE FORM (ADULT)**

*Please provide the following information and answer the questions below; print the form and bring it to your first session. Please note that the information you provide here is protected as confidential information.*

Age:

Gender:

 Male Female Other

Address:

Home Phone:

May we leave a message?  Yes No

Cell Phone:

May we leave a message?  Yes No

E-mail:

May we email you?  Yes No

*\*Please note that e-mail correspondence is not considered to be a confidential medium of communication.*

Marital Status:

 Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/ages:

Referred by:

Have you previously received any type of mental health services?

 No Yes, previous therapist/practitioner(s):

Are you currently taking any prescription medication?

 No Yes, please list:

Have you ever been prescribed psychiatric medication?

 No Yes, please list names and dates:**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. How would you rate your current physical health?

 Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

 Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise to you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing the following...

- overwhelming sadness, grief, or depression?  Yes  No
- anxiety, panic attacks, or have any phobias?  Yes  No
- chronic pain?  Yes  No

Comments:

6. Have you ever felt like life is not worth living?  No  Yes:

7. Have you ever wanted to hurt yourself?  No  Yes:

8. Do you drink alcohol more than once a week?  No  Yes

Amount & frequency:

9. How often do you engage recreational drug use?

- Never  Daily  Weekly  Monthly  Infrequently

10. Are you currently in a romantic relationship?  No  Yes

Name:

Time together?

Please rate your relationship on a scale of 1 (poor) to 10 (great):

11. What significant life changes/stressful events have you experienced recently:

**FAMILY MENTAL HEALTH HISTORY**

*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.).*

<b><u>IDENTIFIED PROBLEM</u></b>	<b><u>✓ IF ISSUE</u></b>	<b><u>LIST FAMILY MEMBER(S)</u></b>
Alcohol/Substance Abuse	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	
Domestic Violence	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	
Obesity	<input type="checkbox"/>	
Obsessive Compulsive Behavior	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	
Suicide Attempts	<input type="checkbox"/>	

**ADDITIONAL INFORMATION**

1. Are you currently employed?

Yes,     FULL-TIME     PART-TIME TEMPORARY     No

Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious?     No     Yes

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

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

**LIMITS OF CONFIDENTIALITY**

*Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:* **Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. **Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. **Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. **Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. **Insurance Providers** (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

***I agree to the above limits of confidentiality and understand their meanings and ramifications.***

**Client Signature**

**Today's Date**

*Your typed name will serve as an electronic signature for this form.*