



INSTRUCTIONS FOR FILLING OUT FORMS

Please use a pen (not a pencil) to complete these forms. It will take about 30 minutes for you to complete.

The questions you will find on these forms are helpful in your treatment. The more I understand about your history and your personal situation, the more I will be able to help you. However, if you find some of them too uncomfortable, feel free not to answer them.

These forms take time and effort on your part. Completing them outside of your appointment time will enable you to talk about your more immediate concerns during your appointment. Time used to complete forms during your scheduled session cannot be recovered or rescheduled.

Your Name: _____
New Client Intake 4.20.17

Date: _____
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NEW CLIENT INFORMATION FORM

Please provide the following information. Services are provided for couples, families & individuals ages 18 yrs & above. Couples please complete a separate form.

Today's Date: ____ / ____ / ____

Personal Information

Name:		Age:	Sex:
Date of Birth: / /	Race/Ethnic Group: _____ Primary Language: _____ Other Fluent Languages: _____	Home Phone #: () - OK to leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone #: () - OK to leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address: Apt#:		Marital Status: (please check one) Never Married: ___ Married: ___ Divorced: ___ Widowed: ___ Separated: ___	
City:	State:	Zip:	Emergency Contact:
# of Children:	Their Ages:	Their Phone #: () -	

Please describe what issues you would like to address:

1. _____
2. _____
3. _____

Your Name: _____

Date: _____



*****Please attach a copy of your driver's license [and your spouse's if requesting couple's therapy] when you are submitting this Intake Form. This information will be kept confidential and will only be used to confirm your identity if you are scheduled for video-based counseling session.*****

Education / Employment Information

Last grade completed in school:	Are you employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No
Company Name:	Company Phone:
Company Address:	Present Occupation:
Main occupation during past 5 years:	
Describe your education (# of years of school, special training, etc.)	

Spiritual History

Religious Affiliation:	Do you currently attend a place of worship?:
List a Few Words to Describe Your Personal Faith:	
List Those Who Support You Most Spiritually:	
Do you prefer to include spirituality as part of your counseling process? <input type="checkbox"/> No <input type="checkbox"/> If Yes – How?	

General Information

How would you rate your overall physical health? Excellent Great Good Fair Poor

Do you have any sleep problems? Yes No

If yes, please describe: _____

Please list the names and relationships of the most important people in your life:

1.	4.
2.	5.
3.	6.

Do you have pets? Yes No If yes, please list: _____

Your Name: _____

Date: _____



Did anyone in your family die before you were 18 years old? Yes No

Who? _____

How old were you? _____ Other family deaths? _____

Have you been abused or assaulted? YES NO DON'T REMEMBER (Circle One)

Did you witness abuse between your parents? YES NO DON'T REMEMBER (Circle One)

Did you witness abuse between parent and child? YES NO DON'T REMEMBER (Circle One)

Describe your current living situation:

List everyone currently living in your home, including family and other:

NAME	AGE	BIRTHDATE	RELATIONSHIP

Please circle any of the following strengths you have:

- CONFIDENT HARD WORKER ORGANIZED SYMPATHETIC GOOD LISTENER
- DEPENDABLE SENSITIVE LOGICAL LOYAL GRACIOUS
- DECISIVE RESPONSIBLE UNDERSTANDING SENSE OF HUMOR PATIENT
- OTHER

Are you usually: Early On Time Running Late

Do you exercise regularly? Yes No

If yes, please describe what you do and how often:

Your Name: _____

Date: _____



How often do you watch television?

What are your favorite hobbies and sports?

What do you do for fun?

When you treat yourself, what are things you like to do?

What is your idea of a perfect vacation?

How did you hear about me?

Printed Name: _____ Date: _____

Signature: _____

Printed Name: _____ Date: _____

Signature: _____

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Your Name: _____

Date: _____



THANK YOU FOR COMPLETING THIS FORM

****For office use only****

Date of Initial Session: _____ **Driver's license received?** yes no **ID verified?** yes no

Agreed upon password for phone sessions: _____

5th session update due: _____ New password: _____

10th session update due: _____ New password: _____

15th session update due: _____ New password: _____

Date

Your Name: _____

New Client Intake 4.20.17

Date: _____

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