

NEW CLIENT INTAKE FORM
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PERSONAL AND FAMILY RECORD

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Date _____ Client Name _____ Age _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Email _____ Is it ok to (check all that apply):

text, email, leave messages at home, messages on cell number?

Phone (home) _____ Cell _____ Work _____ best time to call _____

Employer _____ How long _____ Position _____

Circle last year of school completed 9 10 11 12 GED College 1 2 3 4 Other _____

Marital Status:

Single, never married _____ engaged _____ living together- not married _____ separated _____, how long? _____ divorced _____, how long? _____ widow/er _____, how long? _____

If Married ____ Spouse' name _____ Age ____ Occupation _____

How long have you been married to this spouse? _____ Are you happy in this marriage? _____

Total number of prior marriages for you _____ For your spouse _____

Children	Age	Sex	Relationship to You?	Live in your home?
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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COUNSELING HISTORY

Have you ever been to Counseling for any reason? Yes ____ No ____ What reason _____

_____ How long? _____ Counselor _____

Are you presently working with any other Counselor or Psychologist? Yes ____ No ____ What is the reason?

_____ How long? _____ Counselor _____

Are you involved in any other marriage counseling, family counseling, or support groups? Yes ____ No ____
Specify _____

If married, why did you choose to marry? _____

What key pivotal events have redefined your relationship? _____

Do the two of you share physical touch, cuddling, hugging, love making? _____

What are the hot topics that trigger fights? _____

Who referred you to counseling? _____ What is your religious preference? _____
Church affiliation _____ Pastor _____ How strong is the influence of
church in your life? _____

MEDICAL INFORMATION

Family Physician _____ Psychiatrist/Psychologist _____

Are you taking any prescription drugs? Yes ____ No ____ If yes, state the drug name(s), type, and for what
purpose: _____

Who prescribed the drug(s)? _____

How often do you see this doctor(s)? _____

Describe your physical health: excellent good adequate poor.

Have you ever been hospitalized for mental illness or substance abuse? Yes ____ No ____ If yes, for what
reason? _____ How long were you in treatment?

_____ Hospital name _____ How long ago?

_____ Did you continue with outpatient counseling? Yes ____ No ____

Name of counselor _____

IMPACT OF LIFE CIRCUMSTANCES

Please circle LOSSES that you have experienced:

Death of: spouse, child, father, mother, sister, brother, grandmother, grandfather, friend.

Divorce Separation Broken engagement Suicide Miscarriage Abortion Infertility Bankruptcy Homelessness
Career or job loss Other: _____.

Circle any VICTIMIZATIONS you have experienced or been involved with:

Child abuse: physical, emotional, sexual, incest

Spouse abuse: physical, emotional, sexual

Abandonment Rape Robbery Assault Suicide attempt Auto or industrial accident

Major illness Surgery Physical disability Alienation, Other: _____

Circle any PROBLEMS that concern you now:

Relationship(s) with: Spouse Children Parents In-laws Co-workers Friends Teachers

Alcohol Street Drugs Prescription drugs Binge eating Excessive dieting or exercising

Shopping Work too much Procrastination Communication Depression Anger Grief

Gender identity Sex Career Loneliness Mood swings Self-esteem Codependency Stress Fear Anxiety

Feelings about church or God Other _____

INTENSE EMOTIONAL DISTRESS

Current Situation

Are you currently having suicidal thoughts? Yes _____ No _____ If yes, do you have a plan? Yes _____ No _____

Have you attempted suicide recently? Yes _____ No _____ Please explain _____

Are there current homicidal thoughts, plans or attempts? Yes _____ No _____ Please explain _____

Do you have a desire to cause pain to self or others? Yes _____ No _____ Please explain _____

Are you currently in fear for your life or personal safety? Yes _____ No _____ Please explain _____

Are you currently too depressed to care for yourself or family? Yes _____ No _____ Please explain _____

Expectations for Therapy:

Briefly state the nature of the problem as you see it: _____

What changes would you like to make? _____

In signing below, I affirm that the information given on this form is true and complete.

The undersigned, by providing his/her signature agrees to accept the therapy services provided by Julia Nelson, MA, LPCA, MFTA in accordance with and pursuant to the terms and conditions set forth in this agreement.

1) Name (Please print) _____

Signature _____ Date: _____

2) Parent or Legal Guardian (Please print) _____

For Minor _____

Signature _____ Date: _____