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?**
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

How did you hear about me_____? If referred by whom? _____
What is your religious preference? _____ Church affiliation_____
Pastor _____ How strong is the influence of church in your life? _____

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? _____

_____

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

<u>Current Situation</u>

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: _____