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Welcome! Please complete these forms and bring them with you to your first appointment. When you arrive at the office, you will find a row of light switches on the wall. Find my name next to the correct switch, and turn it on. This will let me know you have arrived. Have a seat in the waiting room, and I will be with you soon.

INTAKE INFORMATION

Today's Date: _____ Referred by: _____

CLIENT CONTACT INFORMATION

Name: _____ Age: _____ DOB: ___/____/____ SEX: M / F

Add'l Client(s): _____ Age: _____ DOB: ___/____/____ SEX: M / F

_ _____ Age: _____ DOB: ___/____/____ SEX: M / F

Physical Address:_____ City: _____ Zip Code: _____

Mailing Address (if different): _____

Home Phone: (____)_____ May I leave messages on home phone? YES NO

Cell Phone: (____)_____ May I leave messages on cell phone? YES NO

Work Phone: (____)_____ May I leave messages on work phone? YES NO

E-mail Address: _____ Preferred communication method: _____

In case of emergency, whom may I contact on your behalf? _____

Phone: _____ Relationship_____

CLIENT LIFESTYLE & MEDICAL INFORMATION

Race/Ethnicity: _____ Sexual Orientation: _____

Are you (circle): Single / Married (# Years ___) / Cohabitating / Separated / Divorced / Widowed

Were you adopted? YES or NO Religious/Spiritual Preference: _____

Pregnancies (if applicable): _____ Highest Level of Education: _____

Client's Occupation: _____ Position or Title: _____

Place of Employment:_____ # of Years: _____ Annual Income: _____

Please list immediate family members [partner(s), children, parent(s), sibling(s)]:

Name	Relationship to you	Age or Year of death	Resides with you?
			YES or NO
			YES or NO
			YES or NO
			YES or NO
			YES or NO
			YES or NO
			YES or NO

I get the emotional help and support I need from my family and friends (circle number):

0 1 2 3 4 5 6 7 8 9 10

None Entirely

In general, how happy were you growing up?

0 1 2 3 4 5 6 7 8 9 10

Not at All Extremely

Client's Physician: _____ City and State: _____
Phone: _____ Date of last visit to Physician: ____/_____/_____

Relevant Medical Conditions: 1)_____
2)_____ 3)_____
4) _____ 5) _____
Are you currently taking any medication or supplements? YES or NO

If YES, please list dosage, frequency, and prescribing doctor: _____
_____
_____

Are you currently seeing a psychiatrist? YES or NO If Yes, Name: _____
Please list previous counseling, mental health treatment, and/or psychiatric hospitalizations with approximate dates: _____
_____
_____

Alcohol use (circle)? YES or NO If YES, frequency? ____/day OR ____/week OR ____/month
Cigarette use (circle)? YES or NO If YES, frequency? ____/day OR ____/week OR ____/month
Caffeine use (circle)? YES or NO If YES, frequency? ____/day OR ____/week OR ____/month

Do you exercise? YES or NO If YES, frequency? ____/day OR ____/week OR ____/month

Please check the boxes for the drugs you have ever used:

Drug	Age first used	Age last used	Drug	Age first used	Age last used
Marijuana			LSD/Acid		
Cocaine (coke, crack)			Mushrooms		
Ecstasy			Prescription drugs		
Amphetamines (meth, speed)			PCP		
Heroin/Opium			Inhalants/Solvents/Other		

Family History (check appropriate boxes):

	Mother	Father	Siblings	Aunt	Uncle	Grand-parents
Alcohol/Substance Abuse						
Suicide Attempt						
Suicide Completion						
Depression						
Anxiety						
Bipolar disorder						
Schizophrenia						
ADHD						
Divorce/Marital Problems						
Victim or Perpetrator of Physical or Sexual Abuse						
Significant Physical Illness or Disability _____						

What are the areas of your life for which you are seeking assistance? _____

_____

_____

_____

How long has this been a concern? _____

What have you tried so far?_____

_____

_____

Please list any additional information you feel would be relevant for me to know: _____

_____

_____

_____

Please check the problems or concerns that you would like help with in therapy:

__Academic Concerns	__Legal Concerns
__Addictions	__Loneliness/Lack of Support
__ADHD/learning problems	__Loss, grief, death
__Adjustment to new situation	__Self-esteem
__Alcohol or Drug Concerns	__Medical or Health Concerns
__Anger Management	__Mood Swings
__Anxiety, fear, nervousness	__Panic Attacks
__Bullying/Intimidation	__Paranoia
__Career/job Concerns	__Parenting/Parent-Child Concerns
__Caregiver Stress	__Phase of Life Problems
__Compulsive Behavior	__Phobias/Specific Fears
__Concentration Difficulties	__Physical Abuse/Assault
__Concern with other's well being	__Procrastination
__Cultural/Multicultural Concerns	__Relationship Concerns
__Cutting or Self Injury	__Sexual Abuse or Assault
__Depression, Sadness	__Sexuality Concerns
__Divorce/Separation	__Sexual Dysfunction
__Eating Concerns/Body Image	__Sleep Difficulties
__Emotional/ Psychological Abuse	__Spiritual/Religious Concern
__Family Problems	__Stress or Tension
__Feeling Doomed or Helpless	__Suicidal Thoughts
__Financial Concerns	__Suicide Attempt
__Flashbacks/Nightmares	__Racing/Obsessive Thoughts
__Identity/sense of self	__Trauma
__Impulse Control_	__Trouble Making Decisions or Getting Things Done
_Intimate Relationship Concerns	__Weight Concerns
__Lack of Motivation	__Other: