New Client Intake Form

Client Full Name: ____

Preferred Name: ___________________________ __________

DOB: ________________ Age: ________________ Gender: _________ Ethnicity: __________

SS#: ____________________________ DL#: ______________________________

Address: ____

City: _______________ State: _________________ Zip: ______________

Home Phone Number: _____________________ Cell Phone: _________________________

Email Address: __________ ______________________________

Preferred Communication: ____________________

On what number may we leave confidential messages? __________________________

How did you hear about North Bossier Counseling? ____________________________

Current or highest education level: ____________________________________

EMERGENCY CONTACT INFORMATION	EMPLOYMENT STATUS
Notify: ______________________________	I am: ________________
Phone Number: ________________________	Company: ____________________________
Relationship to Client: _________________	Address: ____________________________
	City: ______________ State: ______ Zip: ______

RELATIONSHIPS & HOUSEHOLD INFORMATION

Marital Status:

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married _____ years
- ☐ divorced _____ years
- ☐ separated _____ years
- ☐ divorce in process
- ☐ cohabiting
- ☐ prior marriages (self)

Intimate Relationship:

- ☐ never been in a serious relationship
- ☐ not currently in a serious relationship
- ☐ currently in a serious relationship
- ☐ not currently looking for a serious relationship

Relationship Satisfaction:

- ☐ very satisfied
- ☐ satisfied
- ☐ somewhat dissatisfied
- ☐ dissatistfied

Children:

Name:	Age:	Gender:
Name: ______________________	Age: ______________	Gender: ______________
Name: ______________________	Age: ______________	Gender: ______________
Name: ______________________	Age: ______________	Gender: ______________
Name: ______________________	Age: ______________	Gender: ______________
Name: ______________________	Age: ______________	Gender: ______________
Name: ______________________	Age: ______________	Gender: ______________

List all persons currently living in your home:

____

____

____

HEALTH & MEDICAL

Primary Physician's Name: ____

Phone Number: ______________________________

Describe current physical health: ☐ Good ☐ Fair ☐ Poor

Medical Problems: ____

____

Current Medications: ____

____

Are you currently being treated by a psychiatrist? ☐ Yes ☐ No

Do you have a mental health diagnosis? ☐ Yes ☐ No If yes, what? ________________

Please list any other diagnoses (past or present):

____

____

____

Have you been in therapy before? __________ If yes, when? ______________________

Reason for termination: ____

PRESENTING PROBLEM

What type of counseling are you seeking?

☐ Individual ☐ Family/Couples ☐ Group ☐ Online/Phone

Primary Reason for seeking counseling? ____

____

____

How severe, on a scale of 1-10 (with 10 being the most severe)**, do you rate your presenting problems?**

LEAST SEVERE ______________________________ MOST SEVERE

How long has this problem been causing you distress?

How do you rate your current level of coping on a scale of 1 – 10 (with 1 being unable to cope)**?**

UNABLE TO COPE ______________________________ ABLE TO COPE

SYMPTOMS:

☐ aggression	☐ fatigue	☐ sexual difficulties
☐ alcohol dependence	☐ hallucinations	☐ sick often
☐ anger	☐ heart palpitations	☐ sleeping problems
☐ antisocial behavior	☐ high blood pressure	☐ speech problems
☐ anxiety	☐ hopelessness	☐ suicidal thoughts
☐ avoiding people	☐ impulsivity	☐ thoughts disorganized
☐ chest pain	☐ irritability	☐ trembling
☐ depression	☐ judgment errors	☐ withdrawing
☐ disorientation	☐ loneliness	☐ worrying
☐ distractibility	☐ memory impairment	☐ other (specify)
☐ dizziness	☐ mood shifts	☐ cutting
☐ drug dependence	☐ panic attacks	________________________
☐ eating disorder	☐ phobias/fears	________________________
☐ elevated mood	☐ recurring thoughts	________________________

SUBSTANCE USE	Current?	Frequency:
☐ alcohol	___________	___________________________
☐ amphetamines/speed	___________	___________________________
☐ barbiturates/owners	___________	___________________________
☐ caffeine	___________	___________________________
☐ cocaine	___________	___________________________
☐ crack cocaine	___________	___________________________
☐ hallucinogens (LSD, etc.)	___________	___________________________
☐ heroin	___________	___________________________
☐ inhalants (gas, glue, etc.)	___________	___________________________
☐ marijuana	___________	___________________________
☐ nicotine/cigarettes	___________	___________________________
☐ PCP	___________	___________________________
☐ prescription: _______________	___________	___________________________
☐ other: ____________________	___________	___________________________

Are you required by a court of law to receive counseling as part of a legal proceeding? ______________________

____ Signature of Client/Client Representative

_______________________ Date