

## New Client Intake Form (Adult)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 \_\_\_\_\_ Gender/Gender Identity : \_\_\_\_\_

Client SSN: \_\_\_\_\_

Cell number: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_  
 \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Email: \_\_\_\_\_

Is it ok to email? \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you currently in counseling? (please check one): \_\_\_\_\_ Yes \_\_\_\_\_ No

**Counseling History:** Please include all psychotherapists, psychiatrists, psychologists, occupational therapists, equine therapists, neurofeedback, or any other types of therapy or treatment you have pursued.

Dates	Therapist	Why	How Helpful (0-10)

Name of primary physician and phone number: \_\_\_\_\_

List any health issues, medical diagnoses, or disabling conditions:

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What medications are you currently taking?

Medication	Dose	For what

Presenting Problems:

Please do your best to express to me *what it feels like to be you* on any given day?:

Can you identify any event or experience that preceded these challenges?

When did you first notice these symptoms (approximately?)

**Client Demographics**

Full legal name: \_\_\_\_\_

Ethnic identification: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Are you currently serving, or have you ever served, in the military? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Please describe any current or past relationship status: \_\_\_\_\_

\_\_\_\_\_

**Family/Home Information- Please list everyone who resides in your home full or part time**

Name	Age	Relationship to You	Full or Part Time Home Member	Gender

**Does anyone else in your family:**

- Have a history of mental illness? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ UNKNOWN

If yes, explain:

- Have a known or suspected history of trauma? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ UNKNOWN

If yes, explain:

**Development & Early History:** Please answer to the best of your ability. If unknown to you, please leave blank.

	YES	NO	UNKNOWN
Was your mother's pregnancy planned?			
Were there any prenatal problems?			
Did the birth mother experience any unusual stress during pregnancy?			
Were you exposed to any drugs or alcohol in utero?			
Were there any problems with delivery?			
Did your birth mother suffer post-partum depression or anxiety?			
Was there any unusual stress in the year after birth?			
As an infant, did you have feeding problems?			
As an infant, did you sleep well?			
Were you separate from your birth mother after birth, even briefly?			

Did you meet developmental milestones?			
As a child, did you struggle with bedwetting/soiling (beyond developmentally appropriate?)			
As a child, did you experience multiple ear infections?			
As a child, were you ever hospitalized?			
As a child, did you ever have a head injury?			

**Would you (or others) describe your childhood in any of these ways during your first years?**

	YES	NO	UNKNOWN
Did not enjoy cuddling			
Difficult to comfort			
Restless			
Head Banging			
Reflux			
Not calmed by being held			
Colic			
Excessive irritability			
Constantly into everything			
Listless/Unresponsive			
Overactive			
Adapted easily to change			
Intense feelings			

Has anyone ever told you that they worried you had a problem with alcohol and/or drugs? Please explain:

Are there parts of your birth history or early childhood years that are unknown or confusing to you?

What changes do you want to see as a result of treatment?

**Concurrent Stressors or Symptoms:**

<input type="checkbox"/> Depressed mood <input type="checkbox"/> Worry/rumination <input type="checkbox"/> Feelings of shame <input type="checkbox"/> Feelings of guilt <input type="checkbox"/> Fatigue/Low energy <input type="checkbox"/> Poor concentration <input type="checkbox"/> Irritability/Anger <input type="checkbox"/> Substance Use issues <input type="checkbox"/> Anxiety <input type="checkbox"/> Hopelessness <input type="checkbox"/> Emptiness <input type="checkbox"/> Social Isolation <input type="checkbox"/> Worthlessness <input type="checkbox"/> Loss of pleasure in hobbies <input type="checkbox"/> Appetite gain/loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Intense crying <input type="checkbox"/> Recurring thoughts/images <input type="checkbox"/> Feelings of panic <input type="checkbox"/> Difficulty controlling emotions <input type="checkbox"/> Loneliness <input type="checkbox"/> Memory problems <input type="checkbox"/> Disorganized thoughts <input type="checkbox"/> Thoughts of suicide <input type="checkbox"/> Attachment issues	<input type="checkbox"/> Disordered eating/food issues <input type="checkbox"/> Migraines <input type="checkbox"/> Scoliosis <input type="checkbox"/> Financial problems <input type="checkbox"/> Sexual trauma/assault <input type="checkbox"/> Employment issues <input type="checkbox"/> Lack of emotional support <input type="checkbox"/> Infidelity/betrayal <input type="checkbox"/> Childhood trauma <input type="checkbox"/> Hypersensitivity <input type="checkbox"/> Dissociation or "Zoning out" <input type="checkbox"/> Childhood physical abuse <input type="checkbox"/> Childhood sexual abuse <input type="checkbox"/> Emotional/mental abuse <input type="checkbox"/> Seeing or hearing unusual things <input type="checkbox"/> Sexual dysfunction/challenges <input type="checkbox"/> Fainting <input type="checkbox"/> Compulsions <input type="checkbox"/> Developmental disabilities <input type="checkbox"/> Temper outbursts/rage <input type="checkbox"/> Death/Loss <input type="checkbox"/> Loud, negative thoughts <input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Fears/phobias <input type="checkbox"/> Chronic pain/Body pains or problems <input type="checkbox"/> Suicide attempts/dates: _____ <input type="checkbox"/> Divorce or separation <input type="checkbox"/> Problems with attachment <input type="checkbox"/> Adoption <input type="checkbox"/> Recent traumatic event <input type="checkbox"/> Communication problems <input type="checkbox"/> Losing time/blackouts <input type="checkbox"/> Sleep too much <input type="checkbox"/> Sleep too little <input type="checkbox"/> Difficulty falling or staying asleep <input type="checkbox"/> Recent traumatic event <input type="checkbox"/> Fertility struggles <input type="checkbox"/> Helplessness <input type="checkbox"/> Feeling disconnected <input type="checkbox"/> Life transition <input type="checkbox"/> Seizures//PNES <input type="checkbox"/> Epilepsy <input type="checkbox"/> Emotional numbness <input type="checkbox"/> Medical issues	<input type="checkbox"/> Nightmares <input type="checkbox"/> Uncontrolled emotions <input type="checkbox"/> Grief <input type="checkbox"/> Gender Identity or Curiosity <input type="checkbox"/> LGBTQ/exploration <input type="checkbox"/> Transgender: _____ <input type="checkbox"/> Problems with relationships <input type="checkbox"/> Childhood neglect <input type="checkbox"/> Substance abuse/overuse <input type="checkbox"/> Self-soothing habits <input type="checkbox"/> Obsessive/compulsive issues <input type="checkbox"/> TBI/concussion <input type="checkbox"/> Self-harming behaviors <input type="checkbox"/> Sensory processing issues <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Difficulty leaving house <input type="checkbox"/> Body repetitive behaviors (skin picking, hair pulling, etc) <input type="checkbox"/> Neurodivergence <input type="checkbox"/> Autism Spectrum <input type="checkbox"/> ADHD challenges <input type="checkbox"/> PICA <input type="checkbox"/> Postpartum <input type="checkbox"/> Legal problems <input type="checkbox"/> Other:
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**Client Signature: (By signing below I am stating that all above information I know to be true at this time):**

\_\_\_\_\_

**Client Signature**

\_\_\_\_\_

**Date**