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New Client Intake Information

Your assistance in completing this questionnaire will be helpful in planning services for you as I work from a systems perspective. If there is any information you would prefer not to share, please let me know.

GENERAL INFORMATION

Full Name: _____ Today's Date: _____

Mailing Address: _____
Street or PO Box Apt. #

_____ WA 98___-___
City State Zip Code

Telephone: (_____)_____ OK to leave a message for you there? ❑Yes ❑ No
Home
(_____)_____ OK to call you @ work? ❑ Yes ❑ No
Work
(_____)_____ OK to leave a message? ❑ Yes ❑ No
Cell Phone

Emergency contact: _____ Phone # _____

Your age: _____ DOB: _____ Social Security Number: _____

Driver's License #: _____

PERSON RESPOPNSIBLE FOR BILL, IF NOT CLIENT

Name: _____ Relationship: _____

Address: ❑Same as client
(If different from client's) Street address or PO Box _____

City _____ State _____ Zip Code _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell: (_____) _____

Insurance Information:

Primary Insurance _____ *Secondary Insurance*: _____
Phone #: _____ Phone #: _____
Contract #: _____ Contract #: _____
Group #: _____ Group #: _____
Subscriber: _____ Subscriber: _____
Subscriber date of birth: _____ Subscriber date of birth:_____
Patient's relationship to subscriber: _____ Patient relationship to subscriber: _____

Education: 9 10 11 HSGrad 13 14 AA BA MA Ph.D.
Circle highest year/degree completed

Occupation: _____ Years in this occupation?_____

Place of Employment: _____ Yrs Employed Here? _____

Previous Employment: _____

How were you referred for my services? _____

May I thank them? (please initial) ___Yes __ No

Please describe your reason(s) for seeking help today:

_____

_____

__ Anger	__Anxiety	__Coping skills	__Depression	__ Relationships
__ +/-Sleep	__Eating disorder	__ Fear/Phobias	__Mental Confusion	__Sexual
__ Alcohol	__Drugs	__Addiction	__ Energy level	__ Stress/tension
__ Weight	__Aggression	__ Antisocial	__ Avoiding people	__Cyber addiction
__ Distracted	__ Elevated mood	__ Fatigue	__ Hyperactive	__ Gambling
__Hallucinations	__ Worry	__Heart racing	__Hopelessness	__Impulsivity
__Irritability	__ Judgment errors	__ Grief	__ Chest pains	__Loneliness
__Obsessive thoughts / rituals		__ PTSD	__Withdrawing	__ Memory lapses
__ Mood shifts	__ Panic attacks	__ Hearing voices	__ Family issues	__ Sexual addiction
__ Court order	__ Sick often	__ Disorganized	__ Scary thoughts	__ Sadness/Tearful

Are you having any suicidal or homicidal thoughts? ❑ No ❑ Yes In the past __ Yes __ No

Briefly describe how the above symptoms impair your ability to function effectively:

_____

_____

_____

Have you or a family member had prior counseling? ❑ No ❑ If yes, please complete the following:

- Therapist's Name(s) and/or Agency: _____
- Approximate Date(s) and length of services: _____
- Persons Involved:_____
- Issues Addressed: _____
- This experience was: ❑ very helpful ❑ somewhat helpful ❑ not helpful ❑ made things worse

Have you had any hospitalizations? __ Yes __ No
If yes describe: _____
Have you had any drug/alcohol treatment? __ Yes __ No
If yes describe: _____
Have you been involved in any self-help groups? __ Yes __ No
What was your reaction to the overall experience? _____

MEDICAL INFORMATION

Primary Physician: _____Last seen? _____Telephone (____)_____
Address:_____

Current health problems for which you are receiving treatment: ❑None
_____
_____

List any medications you are currently taking: (This information is mandatory if you are using insurance)

Medication	Dosage	Reason Taken	Date started	Prescribing Provider
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Indicate current use pattern:

- Nicotine ❑ None ❑Occasional ❑Frequent ❑Abuse ❑Addicted ❑Quit in _____ Year
- Caffeine ❑None ❑Occasional ❑Frequent ❑Abuse ❑Addicted ❑Quit in _____ Year
- Alcohol ❑None ❑Occasional ❑Frequent ❑Abuse ❑Addicted ❑In rec. since _____ Year
- Non Rx Drugs ❑None ❑Occasional ❑Frequent ❑Abuse ❑Addicted ❑In rec. since _____ Year
- Prescription Drugs ❑None ❑Occasional ❑Frequent ❑Abuse ❑Addicted

Substance(s) of preference: _____
Describe when and where you typically use substances: _____
_____

Describe how your use has affected your family or friends (including their perceptions of your use): _____
_____

Reasons for use: __ Addicted __Socialization __ Build confidence __Taste __Escape
__Self medication __Other: _____

How do you believe your substance use affects your life? _____
Who or what has helped you in stopping or limiting your use? _____

Does someone in your family present/past have/had a problem with drugs or alcohol? __ Yes __No
If yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __Yes __ No
Have you had adverse reactions or overdose to drugs or alcohol? __ Yes __No
If yes describe: _____
Have drugs or alcohol caused a problem for your job/school? __ Yes __ No
If yes describe: _____

Childhood Development

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes __ No
If yes please describe: _____
Has there been history of child abuse? __ Yes __ No
If yes, which type? __Sexual __ Physical __ Verbal __ Emotional
If yes, the abuse was as a __ Victim __ Perpetrator __ Both

Social Relationships

How do you generally get along with other people: (check all that apply)
__ Affectionate __ Aggressive __Avoidant __ Fight/argue often __ Follower __ Friendly
__ Leader __ Outgoing __ Shy __ Withdrawn __Submissive __ Ambivalent
Gender orientation:_____ Pronoun preference:_____
Sexual orientation: _____ Comments: _____
Sexual dysfunctions __Yes __ No If yes describe: _____
Social groups/supports: _____

Leisure/Recreational

Describe special areas of interest or hobbies (art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)
Activities: _____
How often now? _____
How often in the past? _____

Cultural

To which cultural or ethnic group, if any, so you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? _____
Other cultural information_____

Spiritual

How important to you are spiritual matters? __ Not __Little __Moderate __Much
Are you affiliated with a spiritual or religious group? __ Yes __No
If yes describe: _____
Would you like your spiritual/religious beliefs incorporated into the counseling? __ Yes __No

Legal

Are you involved in any cases (traffic, civil, criminal)? __Yes __No
If yes, please describe: _____
Are you presently on probation or parole? __ Yes __No
If yes please describe: _____
Have you had past violations: __ Yes __ No

__ Traffic violations __ DWI, DUI, etc.: __Criminal involvement __Civil involvement __ Other
If you responded yes to any of the above, please fill in the following information:
Charges: _____
Date(s): _____
Where (city/state): _____
Results: _____

Military

Military experience? __ Yes __No
Where: _____
Branch: _____
Date drafted: _____ Date enlisted: _____ Discharge date: _____ Type of discharge: _____
Rank at discharge: _____
Any other information you want me to know? _____
_____

FAMILY INFORMATION

Partner (if applicable): _____ _____
Years together
Address: ❑Same _____
(If different from client's)

Age: _____ DOB: _____
Relationship Status: ❑Single ❑Living Together ❑Married ❑Life Partners
❑Informally Separated ❑Legally Separated ❑Divorced ❑Other _____

Parents:	Name	Age	Describe w/3 adjectives		
Father	_____	____	_____	_____	_____
Step F.	_____	____	_____	_____	_____
Mother	_____	____	_____	_____	_____
Step M.	_____	_____	_____	_____	_____

Siblings

_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	_____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Children

_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	_____	_____	_____	_____
_____	____	_____	_____	_____

* continue on the back of this form if more room is needed

Any additional information that would assist me in understanding you concerns or problems?

_____
_____
_____
_____
_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____
_____
_____
_____

For staff use

Therapist's signature/credentials: _____ Date: _____
Lynn C. Smythe, M.S, LMFT

Physical exam : _____required _____ Not required

Therapist comments:

_____
_____
_____
_____
_____
_____
_____