Please note: You are free to skip any questions which you prefer not to answer.
If additional space is needed, please use the back of this form.

PSYCHOLOGICAL & COUNSELING SERVICES, PC

NEW CLIENT INTAKE FORM (ADULT)

CLIENT NAME:_____ **DATE OF BIRTH**:_____

TODAY'S DATE:_____ **REFERRAL SOURCE:**_____

PRESENTING PROBLEM/ REASON FOR APPOINTMENT:_____

_____

_____

_____

HAVE YOU EVER SOUGHT HELP FOR THIS CONCERN BEFORE? IF SO, WITH WHOM? WHEN?_____

_____

RACE/ETHNICITY:_____ **RELIGIOUS IDENTIFICATION (IF ANY):**_____

PLACE OF EMPLOYMENT:_____ **POSITION**:_____

HOW LONG HAVE YOU WORKED THERE?_____ WORK PHONE:_____

IF UNEMPLOYED, DATE AND PLACE OF LAST EMPLOYMENT:_____

RELATIONSHIP STATUS: ☐ MARRIED ☐ PARTNERED ☐ DATING ☐ NOT DATING ☐ DIVORCED/ SEPARATED ☐ WIDOWED

NAME OF PARTNER/ SPOUSE:_____ DURATION OF RELATIONSHIP:_____

CHILDREN (NAMES, AGES, EDUCATION STATUS):_____

_____

CUSTODY STATUS (IF APPLICABLE):_____

LIST EVERYONE WHO LIVES AT YOUR HOME:_____

FAMILY OF ORIGIN

PLACE OF BIRTH:_____ WHERE DID YOU GROW UP?_____

AGE MOVED OUT/ LEFT FAMILY:_____

LIST ANY SIBLINGS (NAME, AGE, CITY OF RESIDENCE):_____

PARENTS' NAMES, AGES (IF DECEASED, PLEASE NOTE YEAR):_____

ANY SIGNIFICANT TRAUMA GROWING UP?_____

PHYSICAL ABUSE?_____SEXUAL ABUSE?_____ DOMESTIC VIOLENCE BETWEEN PARENTS?_____

COMPLICATIONS WHEN YOU WERE BORN/ YOUR MOTHER WAS PREGNANT WITH YOU?_____

ANYTHING UNUSUAL ABOUT YOUR CHILDHOOD DEVELOPMENT?_____

FAMILY MEDICAL CONCERNS?_____

ACADEMIC HISTORY

HIGHEST LEVEL/ DEGREE ACHIEVED:_____ INSTITUTION ATTENDED:_____

HIGH SCHOOL GRADE POINT AVERAGE (IF UNKNOWN, ESTIMATE):_____

WHAT WAS SCHOOL LIKE FOR YOU?_____

ANY HISTORY OF ATTENTION OR BEHAVIOR PROBLEMS?_____

ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES?_____

FAMILY ACADEMIC/ LEARNING PROBLEMS?_____

MEDICAL HISTORY

CURRENT MEDICATIONS, REASON TAKING, PRESCRIBING DR.:_____

CHRONIC ILLNESSES?_____

CURRENT MEDICAL CONCERNS?_____

SURGERIES PAST, PLANNED?_____

EMERGENCY ROOM TRIPS?_____

PSYCHIATRIC HISTORY

PRIOR COUNSELING, CLINICIAN SEEN:_____

CURRENT OR PAST PSYCHOTROPIC MEDICATIONS:_____

HOSPITALIZATIONS/ TREATMENT STAYS (DATE, LOCATION):_____

PAST DIAGNOSES:_____

PAST SUICIDE ATTEMPTS:_____

LEGAL HISTORY

PAST LEGAL CHARGES/ CONVICTIONS:_____

PENDING CHARGES:_____

CURRENT DIVORCE/ CUSTODY ACTIONS (INCLUDE WHEN INITIATED AND BY WHOM):_____

CHILDHOOD LEGAL DIFFICULTIES:_____

CHILDHOOD CONDUCT PROBLEMS (fighting, lying, stealing):_____

SUBSTANCE USE/ ADDICTION HISTORY

ALCOHOL PROBLEMS:_____

ILLEGAL DRUG PROBLEMS:_____

INPATIENT TREATMENT PROGRAMS ATTENDED:_____

OTHER ADDICTIONS (SEXUAL, INTERNET, SHOPPING, ETC.):_____

_____

SYMPTOM CHECKLIST

Place a check mark next to the symptoms that you are experiencing. For EACH symptom checked, please note the severity (1-10 from least to most problematic) and how long you have been experiencing this.

- □ Depressed mood
- □ Feeling hopeless
- □ Social withdrawal
- □ Lack of interest in previously enjoyed activities
- □ Changed sleep patterns (too much or too little)
- □ Changed appetite (too much or too little)
- □ Difficulty concentrating

- □ Irritability
- □ Fatigue
- □ Mood swings
- □ Recklessness
- □ Thoughts of suicide
- □ Suicide attempts
- □ Self-harm (cutting, self-mutilating)

- □ Obsessive thoughts
- □ Social anxiety
- □ Panic attacks (check relevant symptoms):
    - o palpitations, pounding heart, or accelerated heart rate
    - o sweating
    - o trembling or shaking
    - o sensations of shortness of breath or smothering
    - o feeling of choking
    - o chest pain or discomfort
    - o nausea or abdominal distress
    - o feeling dizzy, unsteady, lightheaded, or faint
    - o feelings of unreality or being detached from oneself
    - o fear of losing control or going crazy
    - o fear of dying
    - o numbness or tingling sensations
    - o chills or hot flashes

- □ Careless, poor attention to details
- □ Difficulty sustaining attention
- □ Unable to listen to others
- □ Difficulty organizing
- □ Tend to avoid effortful tasks
- □ Often lose necessary things
- □ Easily distracted

- □ Forgetful in daily activities
- □ Fidgety, unable to sit still
- □ Always on the go
- □ Acts as if driven by motor
- □ Talking excessively
- □ Difficulty waiting turn
- □ Impulsive/ acts without thinking first

Other symptoms not noted above:_____

_____

_____

_____

Anything else that would be helpful to know:_____

_____

_____