Seachange
Counseling and Bodywork

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NEW CLIENT INTAKE FORM

I'd like to get some background information from you before we begin working together. The form typically takes no more than 15 minutes to complete. Your completion of it should help me understand your situation more quickly.

I appreciate you taking the time to provide this information.

Current Date: _____/_____/________

Name: ____

Date of Birth:_____/_____/________

Current Address:____
City_________________________State__________Zip___________

Permanent Address:_______________________________________
City_________________________State__________Zip___________

Home Phone:____________________ Cell Phone:________________

May I contact you at home? ___No ___Yes
On your cell phone? ___No ___Yes

May I leave a message on your cell phone? ___No ___Yes
May I leave a message for you at hour home? ___No ___Yes

What is the *best* way to reach you?____________________________

In case of an emergency please notify:_________________________
Emergency Phone Number(s):________________________________
Relationship:____

Do I have permission to contact this person *in case of emergency* only?
___No ___Yes
(If contacted, information will be disclosed with care.)

Demographic Information

Gender: ___Male ___Female ___Transgender
___Other______________________________

What race or culture do you consider yourself? (Please list all that apply.)

Sexual orientation: Heterosexual ___Gay/Lesbian
___Bisexual ___Fluid ___Queer ___Questioning
___Other:________________________

Relationship Status: ___Single ___Engaged ___Married
___Partnered ___Separated ___Divorced
___Remarried ___Widow/Widower

Is your spouse/partner basically supportive of your seeking counseling?
___No ___Yes ___n/a

Number of Children:_________
Children's Names and Ages: ___________________________________
____

Academic Status (if you are a student):____________________________
Academic Institution, Year:_______________________________________

Referred by: ___Self ___Family ___Friend
___Health Care Professional ___Other_______________

If you were referred by a fellow professional (doctor, therapist, acupuncturist, etc.), may I contact this person to thank them for the referral (*without disclosing any information about you*)? ___No ___Yes

Treatment Information

Have you had previous counseling? ___No ___Yes
If yes, when?__________________________________

With whom?

For what issue?

With what general results?

Do you take any medication for mental health reasons? ___No ___Yes
If yes, which ones, what dosage, and for how long?

Have you ever been hospitalized for a psychiatric reason?
___No ___Yes
When and for what reasons?

Have you ever had substance abuse treatment? ___No ___Yes
When and for what?

Do you participate in any support groups? ___No ___Yes
If yes, which?

Please check if you have experienced any of the following types of trauma or loss:

___Emotional abuse ___Sexual abuse ___Crime victim

___Multiple family moves ___Placed a child for adoption

___Teen pregnancy ___Homelessness ___Neglect

___Physical abuse ___Violence in the home

___Parent/guardian death during childhood
If yes:___Father ___Mother Your age at the time__________

___Parent/guardian substance abuse ___Parent/guardian illness during childhood

___Lived in foster home ___Other (please specify):

Medical Information

When was your last physical?_____________________________________

Name of your primary care provider________________________________
Phone number_________________________________

Have you ever experienced any of the following medical conditions?

___Head Injury ___Seizures ___Migraines

___Digestive Problems ___Fainting spells

___Asthma ___Miscarriage/Stillbirth ___Diabetes

___Chronic Pain ___Abortion ___STD

___Cancer ___Traumatic accident/injury ___Physical disability

___Chronic, long-term disease ___Cardiovascular problems

___Joint tightness/loss of range of motion ___Neck/back problems

___Skin disorders ___Loss of hair (women) ___Other (Please specify):

Please list any **current** health concerns:

Please check all of the behaviors and symptoms that are concerns for you:

___Anxiety issues ___Eating problems ___Parenting problems

___Frequent worry ___Withdrawal from people ___Panic attacks

___Relationship problems ___Sexual problems ___Flashbacks

___Self-harm behaviors ___Social discomfort ___Nightmares

___Sleep problems ___Work/school problems ___Social isolation

___Fear away from home ___Thoughts of death/suicide

___Problems with pornography ___Obsessive thoughts

___Gambling problems ___Computer addiction ___Alcohol use

___Drug use ___Compulsive behavior ___Suspicion/paranoia

___Racing thoughts ___Hearing voices ___Visual hallucinations

___Cultural adjustment ___Spiritual/religious matters

___Death of a loved one If yes, who and when?____________________
____

___Mood Issues:
- ___Crying spells
- ___Sadness/depression
- ___Fatigue
- ___Lack of motivation
- ___Hopelessness
- ___Guilt
- ___Inability to enjoy
- ___Low self-worth
- ___Shame
- ___Mood swings

___Anger issues:
- ___Physical aggression
- ___Irritability/anger
- ___Homicidal thoughts
- ___Peer conflict
- ___Property destruction

___Attention issues:
- ___Distractibility
- ___Hyperactivity
- ___Impulsivity
- ___Easily confused
- ___Poor memory

___Specific phobias (please specify):

___Other:

Please state the reason(s) and concern(s) for which you are seeking counseling at this time, and any other helpful information:

How long have these concerns been bothering you?

Have you ever in your lifetime had thoughts of harming yourself?
___No ___Yes If yes, when most recently?

Have you purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling, etc.)? ___No ___In the past, stopped
___Yes, currently

In the last week, have you had suicidal thoughts (i.e., thoughts of killing yourself)? ___No ___Yes

If yes, what is the frequency?
___Rarely ___Sometimes ___Frequently ___Always

What is the duration? ___Seconds ___Minutes ___Hours ___Constant

What is the intensity?
___Brief and fleeting ___Focused deliberation ___Intense rumination

Have you seriously considered attempting suicide in the past?
___No ___Yes

Have you ever attempted to commit suicide? ___No ___Yes
If yes, when?

Did you receive help? ___No ___Yes

Where/from whom?

Have you seriously considered harming another person? ___No ___Yes
If yes, whom? When?

Have you intentionally physically harmed someone? ___No ___Yes
If yes, whom? When?

Have you ever been physically hurt/threatened by someone? ___No ___Yes
If yes, when?

What have you found *helpful* for coping with difficult times?

What do you consider to be your own greatest gifts/strengths?

Family Information

___One or both parents deceased (Please specify):
If during childhood, your age at death of mother_____ or father_____

___Parents married/partnered and living together

___Parents divorced or separated
Your age at parents' separation:__________

___Mother remarried - number of times:________

___Father remarried - number of times:_________

Your siblings and their ages:

Have any of your *family members* experienced any of the following (Please indicate who):

___Attention/Hyperactivity problems ___Suicide attempts

___Anxiety ___Eating Disorder

___Panic attacks ___Sexual abuse survivor

___Obsessive/Compulsive behavior ___Alcohol abuse

___Depression ___Drug Abuse

___Manic Depression (bipolar) ___Schizophrenia

___Abusive behavior ___Anger management problems

___Addictions (please specify):

Substance Use

How often do you drink caffeine:

Do you regularly use alcohol? ___No ___Yes
If yes, _______ drinks/beers/glasses of wine per ___day___week ___month

In a typical month, how often do you have 4 or more drinks in a 24-hour period?
___Never ___Rarely ___Monthly___Weekly ___Daily or almost daily

Do you consider your alcohol consumption a problem? ___No ___Yes

Have you used any drug in the past 30 days that was not prescribed by a doctor (for example, marijuana, meth, cocaine, diet pills, ecstasy, Xanax, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other?)
___No ___Yes

How often do you engage in recreational drug use?
___Never ___Rarely ___Monthly ___Weekly ___Daily or almost daily

Has anyone ever expressed concern about your drinking or drug use?
___No ___Yes
Have you ever tried to stop your drinking or drug use, but could not?
___No ___Yes

Miscellaneous Information

Are you currently employed? ___No ___Yes

If yes:
Employer:____

Position:____

Length of time in this position:_______________

Stress level of this position: ___Low ___Medium ___High

Have you been/are you now in the military? ___No ___Yes
If yes, were you in combat? ___No ___Yes
When/where?____

Have you been convicted of a felony? ___No ___Yes
If yes, what/when?

Are you currently involved in any divorce or child custody proceedings?
___No ___Yes
If yes, please explain:

Are you involved in any type of spiritual practice? ___No ___Yes

If yes, please briefly describe:

Do you have a local support network (friends, family, church, temple, etc)?
___No ___Yes
If yes, please briefly describe:

Please answer the next 5 questions based on how you've felt in general over the past week:

I feel sad, blue, or down...
___I do not feel sad, down, or blue.
___rarely.
___sometimes.
___often (more times than not).

My appetite...
___My appetite is normal and hasn't changed.
___is somewhat lower OR higher than normal.
___is significantly lower OR higher than normal
___has changed so much that I do not want to eat at all
___I want to eat all the time.

My energy level...
___My energy level is normal.
___is noticeably lower than normal.
___is much lower than normal.
___is so low that I can hardly conduct my daily activities.

I have lost interest and pleasure in things that I usually enjoy...
___I have interest in things I usually enjoy and get as much pleasure from them as I always have.
___I have lost some of my interest in things, but still enjoy activities and get pleasure from some activities.
___I have lost interest and pleasure in most things.
___I have lost interest and pleasure in all things.

I feel guilty and down on myself...

___I do not feel guilty or down on myself.
___sometimes.
___much of the time.
___all of the time.

Relationships

Please rate on the scale of 1 to 5, with 1 being low and 5 being high:

The general relationship you had/have with your father(s):________

The general relationship you had/have with your mother(s):________

The general relationship you had/have with your siblings (could vary with each sibling; if so, indicate “varies”):________

If you are in an intimate relationship, rate it in general terms:________

Your feelings regarding your current social network:________

If you have a job, rate your relationship with your work colleagues:_______

If you have children, rate your relationship with them (could vary with each child; if so, indicate “varies”):________

If there is any other information you would like to provide, please feel free to include it here: