NEW CLIENT INFORMATION & INTAKE FORM

(Confidential)

Please answer all of the questions below and bring this form with you on the day of your first appointment. Thank you.

Name:_____

Address:_____

Date of Birth:_____

Email:_____

Phone:_____

Please provide any instructions regarding messages that may be left on your email or phone:

_____

Are you: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Current Occupation:_____

Number of Children and Current Ages:_____

Physician's Name:_____ Date of Last Visit:_____

Please list any family history of major physical, mental or addiction issues:

_____

_____

Please list any chronic medical conditions or serious illnesses/injuries:

_____

_____

_____

Please list your current prescriptions/medications:

_____

_____

Please check any of the below that you believe apply to you now, or in the past:

_____Financial or legal concerns

_____Substance abuse of alcohol or other drugs

_____Cigarette smoking or vaping

_____Gambling addiction

_____Sex addictions

_____Eating issues

_____Chronic weight concerns

_____Anorexia or bulimia

_____Insomnia or other sleep concerns

_____Stress

_____Anxiety

_____Phobias or fears

_____Sexual/gender concerns

_____Relationship issues

_____Grief or bereavement

_____Psychiatric history

_____Trauma of any kind

_____Depression or mood concerns

_____Suicidal thoughts or actions

_____Family conflicts and concerns

_____Work or career issues

_____A current major life event or illness/accident

Have you ever been in therapy or counseling in the past? If so, when?_____

Please provide additional information that you think is important:_____

_____