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New Client Intake Form

Name/s: _____

Date of first appointment: _____

Please take your time providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential. If there is a question that you would prefer not to answer, please feel free to leave blank and discuss in session.

Referred by: Please circle

Website: http://www.megcanhelp.com
Psychology Today
Self-Referral
Therapist/Psychiatrist Referral
Spouse/Family/Friend
Google Search for EMDR Trauma Therapy
Google Search for Marriage & Family Therapy

_____
Medical Provider:
_____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Name of provider or facility:
_____

Location:
_____

Dates of treatment:

_____

Reason for treatment:

_____

Briefly, what brings you in today?

When did your problem first begin? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?
□ Physical Health □ Primary Relationship □ Friendship □Employment □ Legal

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced since childhood:
(Use a separate sheet of paper if needed)

What significant life changes or stressful events have you experienced recently?
□ Divorce □Job Change □ Breakup □ Death of loved one □ Moving

What would you like to accomplish from your time in therapy, your goals?

Family History

Where were you born?

_____

Where did you grow up?

_____

□ city □ suburbs □ country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	

Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:
□ Never Married
□ Domestic Partner □ Married

For how long?_____

Please give partners name: _____

On a scale of 1-10 (best) how would you rate your relationship? _____

□ Separated □ Divorced □ Widowed

If widowed, please give partners name, and year deceased:
_____

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information:
Name:

_____

Specialty:

_____

Facility:

_____

Phone, email, or Fax:

_____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise to you participate in?

Please list any difficulties you experience with your appetite or eating patterns:

_____

Any change in weight over the past year? □ No □ Yes:

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

What do you feel I need to know about you and your situation that has not been addressed already in this form?