Positive Changes Counseling Center, Debbie Disney, LCSW-C, LLC

New Client Intake Form: Adult, Ages 18 and Above

Please fill out the form below and bring to your first session.
Please note: the information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Birth Date of Client: ______/_______/________ Age: ________ Gender: ______________

Insurance type (Aetna, BCBS, Cigna, etc.): ____

Name of Primary Insurance Policy Holder: ____

Birth Date of Insurance Policy Holder: ________/_________/_________

Address: ____
(Street and Number)

____
(City) (State) (Zip Code)

Cell Phone: ( ) May we leave a message? ____Yes ____ No

May we leave a text message on your cell phone? ____Yes ____ No

Email: ____

May we email you? ____Yes ____ No

***Please note: Email correspondence and text messaging are not considered to be confidential mediums of communication.**

How did you find us? ____

Please list any children and their age(s):

Name	Age	Gender	Lives
________________________	____	____F ____M	__Home __Away
________________________	____	____F ____M	__Home __Away
________________________	____	____F ____M	__Home __Away

________________________ ____ ____F ____M __Home __Away

Marital Status:

____ Single ____ Domestic Partnership ____ Married ____ Separated

____ Divorced ____ Widowed

If currently in a romantic relationship, how long? ____

On a scale of 1-10 (1 being extremely dissatisfied and 10 being very satisfied), how would you rate your relationship? ____

Work/School:

Are you currently employed? ____ Yes ____ No
If yes, what is your current employment situation? ______________________________________

Are you currently a student? ____ Yes ____ No
If yes, please provide the name of your school and grade: _________________________________
____

Do you enjoy work/school? Is there anything stressful about your current work/school?
____
____

Family Mental Health History:

In the section below, please 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 (ex. Maternal grandmother, father, paternal grandfather, etc.)

	Please Circle:	Family Member(s):
ADHD/ADD	Yes / No	__________________________
Alcohol/Substance Abuse	Yes / No	__________________________
Anxiety	Yes / No	__________________________
Depression	Yes / No	__________________________
Domestic Violence	Yes / No	__________________________
Eating Disorders	Yes / No	__________________________
Disordered Eating	Yes / No	__________________________
Obsessive Compulsive Behavior	Yes / No	__________________________
Mental Illness	Yes / No	__________________________

Suicide	Yes / No	________________________
Other: __________________	Yes / No	________________________

General Health and Mental Health Information:

Name of Primary Care Provider: ____

Have you previously received any type of mental health services (psychotherapy, psychiatrist services, etc.)? ____ Yes ____ No

If yes, please list previous therapist: ____

Have you ever been prescribed psychiatric medication? ____ Yes ____ No

If yes, please list and provide dates you were first prescribed: ___________________________
____

Are you currently taking any prescription medication? ____ Yes ____ No

If yes, please list: ____

Name of Psychiatrist or Medical Practitioner: ____

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

Please list any specific sleep problems you are currently experiencing: ____________________
____

Do you regularly exercise? ____ Yes ____ No
If yes, about how many times per week and what type of exercise do you partake in?
____
____

Do you have difficulties with your appetite or eating patterns?

____
____
____

Are you experiencing sadness, grief, or depression? ____ Yes ____ No

If yes, for approximately how long? ____

Please explain: ____

Are you experiencing anxiety, anxiety attacks, or panic attacks? ____ Yes ____ No

If yes, for approximately how long have you been experiencing this? ____________________
____

Please explain: ____

Do you have any phobias? ____ Yes ____ No

Please explain: ____

Are you experiencing chronic pain? ____ Yes ____ No

If yes, please explain: ____

Is there a history of self harm, suicidal thoughts, etc.? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No

If yes, how often? ____

Do you engage in recreational drug use? ____ Yes ____ No

If yes, how often? ____

Do you use a medical marijuana card? ____ Yes ____ No

Have you experienced any significant life changes or stressful events?
____
____
____
____

What self care activity do you enjoy? ____

____

What do you consider to be your strengths?

____

____

What do you consider to be your weaknesses?

____

____

Please describe the main difficulties or concerns that have brought you to therapy.

____

____

____

____

____

____

Please check any behaviors/symptoms that occur more often than you would like them to:

_____ Aggression
_____ Alcohol dependence
_____ Anger
_____ Antisocial behaviors
_____ Anxiety
_____ Avoidance behaviors
_____ Depression
_____ Drug dependence
_____ Disordered eating
_____ Elevated mood

_____ Fatigue
_____ Gambling
_____Hallucinations
_____ Hopelessness
_____ Impulsivity
_____ Irritability
_____ Judgment errors
_____ Loneliness
_____ Mood swings
_____ Panic attacks

_____ Phobias/fears
_____ Recurring thoughts
_____ Self esteem
_____ Sexual addiction
_____ Sexual difficulties
_____ Sleeping problems
_____ Social anxiety
_____ Suicidal thoughts
_____ Worrying
_____ Other: ________________

What are your goals for therapy?

____

____

____

Is there anything else you would like me to know about you that is not on this form?

____

____

____

____