New Patient Intake Form

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Presenting Problem

What is/are the reason(s) you are seeking therapy today?

Did a specific event lead to this request for service? ☐ Yes ☐ No If yes, please describe the incident.

Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy.

How long has the problem been present?

What solutions to the problem have you tried, and what were the results?

How much does this problem affect your life on a scale from 0-10? *(0- Not at all 10- significant affect)*

1. Personally 2. Family life

3. Socially 4. Work-wise

How were you referred to this service? *(Please check box)*

☐ Self ☐ Spouse/Other ☐ Physician ☐ Employer ☐ Court

☐ Other *(Please specify):*

Symptoms

Please look these items over and check what best describes how these symptoms have bothered you **recently**.

- ☐ Depressed, sad, or crying
- ☐ Guilty feelings
- ☐ Suicidal thoughts, plans, or attempts. Have you ***ever*** thought about, planned or attempted suicide?
- ☐ Changed sleep patterns/ appetite patterns?
- ☐ History of restrictive eating, dieting or purging
- ☐ Insecurity or inferiority
- ☐ Loss of interest or energy in pleasurable activities
- ☐ Anxious, nervous, or panicky feelings
- ☐ Avoiding places or situations
- ☐ Repetitive thoughts or behaviors
- ☐ Change in work habits
- ☐ Change in spending habits
- ☐ Anger or temper problems
- ☐ Flashbacks or intrusive memories
- ☐ Physical problems, pain, or illness
- ☐ Sexual worries or problems
- ☐ Brain fog, fuzzy thinking or dissociation
- ☐ Memory problems
- ☐ Confused or disorganized thoughts
- ☐ Periods of high energy/activity with less need for sleep

Do any of the following concerns contribute to your symptom(s)? *(Check all that apply)*

☐ Family move to a new home	☐ Birth of child or sibling	☐ Empty nest
☐ Fighting with spouse	☐ Post-divorce adjustment	☐ Developmental problems
☐ Financial stress	☐ Marital unfaithfulness	☐ Compulsive gambling/spending
☐ Parenting problems	☐ Spiritual problems	☐ Suspect physical/sexual abuse
☐ Death of a family member	☐ Adjustment to new job	☐ Alcohol/Substance abuse
☐ Adjustment to school	☐ Law violations	☐ Pornography use
☐ Dishonesty	☐ Career concerns/unemployment	☐ Anger/Violence
☐ Known physical/sexual abuse	☐ Previous therapy	☐ Other: _____

Mental Health & Medical History

Who is your primary care physician and your primary clinic?

Who else do you regularly see as part of your routine health care?

List any significant health problems, past or present, including surgeries and/or illnesses with the ***corresponding dates***.

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list:

Have you ever taken any medications for depression, anxiety, or mental health issues?
☐ Yes ☐ No If yes, please list:

Do you have any allergies to medications? ☐ Yes ☐ No
If yes, please list and describe the reaction.

List other therapy or counseling you have received in the past or are receiving now:

If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form. To receive a **Release of Information** form, please check here ☐.

Have you ever been hospitalized for mental or nervous problems? ☐ Yes ☐ No If yes, when and where?

Substance Use

Please describe your use of the following substances:

Caffeine _____ Tobacco _____

Alcohol _____ Prescription drugs _____

Inhalants _____ Street drugs _____

Have you ever experienced any of the following as a result of substance use?

Blackouts Bad reactions Withdrawal symptoms Overdose DUI Other: _____

Please give details

Have you ever felt you should **cut down** on your drinking or drug use? Have people **annoyed** you by criticizing your drinking or drug use? Have you ever felt bad or **guilty** about your drinking or drug use?

Have you ever had a drink or used drugs as an **eye-opener** first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?

Have you ever had treatment for any type of alcohol or substance use?

What has helped you manage or endure your current problem?

Please describe the people in your life that currently play a supportive, influential, or friendship role.

What interests or passions give meaning to your life?

Do you have any spiritual beliefs or practices that are important to you ? ☐ Yes ☐ No If yes, please explain:

What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of?

Family Information

Please list those who you consider part of your immediate family and/or your current household.

Name

Age

Relation to you

Living with you?

Other

Is there anything else that you would like Dr. Delpassand to know that you have not written about on any of these forms?

☐ Yes ☐ No If yes, please tell me about it here or on another paper:

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform Dr. Delpassand of any changes in my personal circumstances including, symptoms experienced, suicidal thoughts and substance use.

_____

Client Signature

_____

Date