Alder Psychological Services, LLC

New Client Intake Form

Full Name: _____ Today's date: _____
Gender pronouns: _____ Birthdate: _____
Age: _____ E-mail: _____
Address: _____
Phone Number: _____ □ home □ mobile □ work
Is it okay to leave a message at this number? □ yes □ no
Have you previously attended therapy? □ yes □ no
If yes, please describe (e.g. dates, therapist): _____
_____
Emergency Contact (name and number): _____
_____

Presenting Problems and Concerns

Briefly describe your goals for counseling: _____
_____
_____

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

□ Distractibility	□ Change of appetite	□ Suspicion/paranoia
□ Hyperactivity	□ Lack of motivation	□ Racing thoughts
□ Impulsivity	□ Withdrawal from people	□ Excessive energy
□ Boredom	□ Anxiety/worry	□ Mood swings
□ Poor memory/confusion	□ Panic attacks	□ Sleep problems
□ Seasonal mood changes	□ Fear away from home	□ Nightmares
□ Sadness/depression	□ Social discomfort	□ Eating problems
□ Loss of pleasure/interest	□ Obsessive thoughts	□ Parenting problems
□ Hopelessness	□ Compulsive behaviors	□ Sexual problems
□ Thoughts of suicide	□ Aggression/fights	□ Alcohol/drug use
□ Self-harm behaviors	□ Frequent arguments	□ Problems with pornography
□ Crying spells	□ Irritability/anger	□ Gambling problems
□ Loneliness	□ Relationship problems	□ Thoughts of harming others
□ Low self-worth	□ Flashbacks	□ Work/school problems
□ Guilt/shame	□ Hearing voices	□ Recurring disturbing memories
□ Fatigue	□ Hallucinations	□ Other: _____

□ yes □ no Have you ever had thoughts about or attempted to harm yourself?
If yes, please explain: _____

□ yes □ no Have you ever had thoughts about, made statements concerning, or attempted to harm someone else? If yes, please explain: _____
_____

□ yes □ no Have you recently been physically threatened or harmed by someone else?
If yes, please explain: _____

Family of Origin and Social/Cultural History

Where did you grow up? _____
Father's age and occupation: _____
Mother's age and occupation: _____
Are your parents married? □ yes □ no How long are/were they married? _____
If divorced, how old were you when they divorced? _____
Describe your relationships with your parents: _____
_____
List your siblings and their ages: _____
_____
Were you adopted? □ yes □ no
Has anyone in your immediate family died? □ yes □ no If yes, please explain: _____
_____

Has anyone in your family been diagnosed with or treated for:

□ Bipolar disorder	□ Schizophrenia	□ Depression
□ Post-traumatic stress	□ Anxiety	□ Alcohol abuse
□ Other substance abuse	□ Anger	□ Suicide
□ Violence		

If you marked any of these, please describe: _____
_____
Have any family members been treated with psychiatric medication? □ yes □ no
If yes, please describe: _____

Please describe your social support (check all that apply):
□ Family □ Neighbors □ Friends □ Students □ Co-workers
□ Support/Self-help group □ Community group □ Religious/spiritual center

To which cultural or ethnic group do you belong? _____
If you are experiencing any problems related to culture or ethnicity, please describe: _____
_____

How important are spiritual matters to you?
□ Not at all □ A little □ Somewhat □ Very much
Would you like spiritual/religious beliefs to be incorporated in counseling? □ yes □ no
What is your religious/spiritual affiliation? _____

Please describe strengths/skills/talents: _____
_____
Please describe areas of interest/hobbies: _____
_____

Relationship History

How do you identify your sexual orientation?:
□ heterosexual/straight □ lesbian/gay/queer □ bisexual □ pansexual
□ unsure/questioning □ asexual □ prefer not to answer □ other

Are you currently:
□ Single □ Married □ Partnered □ Divorced □ Separated □ Widowed
How long?: _____ Are you sexually active? □ yes □ no
What is your spouse/significant other's occupation? _____
Describe your relationship with him/her/other: _____
_____
Have you previously been married? □ yes □ no How many times? _____
Do you have children? □ yes □ no If so, please list ages and gender: _____
_____
Describe your relationships with your children: _____
_____
_____

Occupation/Education History

Are you currently:
□ Working □ Unemployed □ Disabled □ Retired
Employer: _____ Job title: _____
Length of time in position: _____ Previous employment: _____
_____
Have you ever been fired? □ yes □ no

Are you currently attending school? □ yes □ no
Highest level of education:
□ High school or □ GED Year: _____
□ Associate's degree Year: _____ Major area of study: _____
□ Undergraduate degree Year: _____ Major area of study: _____
□ Graduate degree Year: _____ Major area of study: _____
□ Other Please describe: _____

Legal History

Have you ever been arrested? □ yes □ no If yes, please describe: _____
_____
_____
Are you currently on probation? □ yes □ no Parole? □ yes □ no

Military Service

Have you ever been/are you currently in the military? □ yes □ no
Branch: _____ Date of discharge: _____

Type of discharge: _____ Rank: _____
Were you in combat?: □ yes □ no

Medical History

Medical doctor: _____ Date of last exam: _____

Have you experienced any of the following medical conditions during your lifetime?:

□ Allergies □ Serious accident □ Headaches □ Stomach aches
□ Asthma □ Head injury □ Dizziness/fainting □ Vision problems
□ Surgery □ Meningitis □ Seizures □ High fevers
□ Abortion □ Miscarriage □ Chronic pain □ Diabetes
□ Sleep disorder □ Sexually transmitted disease □ Other: _____

Do you have any medical concerns you would like to discuss? □ yes □ no
CURRENT health concerns: _____

_____

Please list all current medications, including dosage and start date: _____

_____

Hospitalizations (date, reason): _____
Relevant family medical history: _____

_____

_____

Do you exercise regularly? □ yes □ no
If yes, please describe: _____

Substance Use

Have you ever tried the following?			If yes, how long and date of recent use:
□ yes	□ no	Methamphetamine	_____
□ yes	□ no	Cocaine	_____
□ yes	□ no	Stimulants	_____
□ yes	□ no	Heroin	_____
□ yes	□ no	LSD or hallucinogens	_____
□ yes	□ no	Marijuana	_____
□ yes	□ no	Painkillers (not as prescribed)	_____
□ yes	□ no	Methadone	_____
□ yes	□ no	Tranquilizers/Sleeping pills	_____
□ yes	□ no	Alcohol	_____
□ yes	□ no	Ecstasy	_____
□ yes	□ no	Other (please describe)	_____

Have you ever been treated for alcohol or drug abuse? □ yes □ no
If yes, please explain (e.g. date and location of treatment): _____

_____

How many days a week do you drink alcohol? _____
How many drinks do you have (on average) in one sitting? _____

Have you ever felt you ought to cut down on your drinking or drug use? □ yes □ no
Have people annoyed you by criticizing your drinking or drug use? □ yes □ no
Have you ever felt bad or guilty about your drinking or drug use? □ yes □ no
Do you think you have a problem with drugs or alcohol? □ yes □ no
Have you ever abused prescription medication? □ yes □ no

How many caffeinated beverages do you drink a day?
Coffee: _____ Soda: _____ Tea: _____
Have you ever smoked cigarettes or pipe/chewed tobacco? □ yes □ no
If yes, what amount per day? _____ For how long? _____

Trauma History

Have you ever been abused emotionally, sexually, physically, or by neglect? □ yes □ no
Have you ever been sexually assaulted or harassed? □ yes □ no
Have you ever abused (emotionally, sexually, physically, or by neglect) someone else?
□ yes □ no
Have you ever sexually assaulted or harassed someone else? □ yes □ no
If you answered "yes" to any of these questions, please explain: _____

_____

_____

Miscellaneous

Is there anything else I should know?: _____

_____

_____

_____

_____

Signature: _____ Date: _____

Guardian signature (if under 18): _____ Date: _____

Office use only:

Reviewed by: _____ Date: _____

Client #: _____