

# New Client Intake

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## CONTACT INFORMATION

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_ DOB: \_\_\_\_\_  
Single \_\_\_\_ Living together \_\_\_\_ How long \_\_\_\_ Married \_\_\_\_ # of times \_\_\_\_ Divorced \_\_\_\_ Widow \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Type of Work: \_\_\_\_\_ How long \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ relation \_\_\_\_\_ Ph # \_\_\_\_\_  
How you found me: Psych.Today\_\_TerriMilen.com\_\_ Referred by \_\_\_\_\_ Other \_\_\_\_\_

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## FAMILY MEMBERS (spouse, children, parents, siblings, in-laws)

Name	Relationship	Age/Date of Birth	Living Where?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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## PERSONAL / HEALTH HISTORY

Education \_\_\_\_\_ Previous Employment \_\_\_\_\_  
Major life changes: \_\_\_\_\_  
Exercise/Dietary Habits \_\_\_\_\_ Leisure Activities \_\_\_\_\_  
Prescriptions/OTC/Supplements/Vitamins/Herbs/Reason: \_\_\_\_\_  
Tobacco/Marijuana/Alcohol/Drugs (circle) how long/often \_\_\_\_\_  
Physical/Verbal/Psychological/Sexual Abuse (you, your family) \_\_\_\_\_  
Past Hospitalizations: Procedure, Reason, Date \_\_\_\_\_  
Current health issues, if any: \_\_\_\_\_  
Previous Counseling/Support Groups (i.e. AA, NA, Alanon, etc.) \_\_\_\_\_

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**RELATIONSHIPS – spouse, parents, siblings, friends, children, coworkers**

Qualities/Shortcomings you bring to your relationships \_\_\_\_\_

Those others would say you bring to your relationships \_\_\_\_\_

**IF APPLICABLE:** What attracted you to your partner \_\_\_\_\_

What you feel attracted your partner to you \_\_\_\_\_

One thing you would change about your partner \_\_\_\_\_

One thing you feel your partner would change about you \_\_\_\_\_

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**YOUR CHILDHOOD** (when you were in it)

What you liked most about your upbringing \_\_\_\_\_

What you loved most about your parents \_\_\_\_\_

What you lacked most in your upbringing \_\_\_\_\_

What you lacked most from your parents \_\_\_\_\_

What you saw in your friends that you envied \_\_\_\_\_

What you saw in your friend's upbringing that you envied \_\_\_\_\_

What your friends liked most about you \_\_\_\_\_

What your friends liked most about your upbringing/parents \_\_\_\_\_

What did you want to be/do when you grew up \_\_\_\_\_

Your biggest struggle as a child/teenager/young adult \_\_\_\_\_

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**GOALS FOR COUNSELING AND FOR YOUR LIFE**

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## How would you like to change your life?

Please check or write the goals that are important to you.

### Mood

	Feel less depressed
	Feel more self-confident
	Feel less guilt
	Reduce my fear of:
	Become more optimistic
	Better manage my temper
	Better accept the death of:
	Discuss my thoughts of harming myself or others
	Other:
	Better tolerate my mistakes
	Learn to problem solve or make decisions
	Worry less about:
	Other:
	Learn how to relax
	Improve my sleep
	Improve my energy
	Improve my focus/concentration
	Other:
	Reduce family difficulties
	Improve communication with my spouse / children / friends / coworkers /
	Learn to express myself assertively
	Learn how to improve friendships
	Learn more effective parenting skills
	Improve my sexual relationship
	Other:

### Thoughts

### Physical

### Relationships



**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_