New Client Intake

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Please provide the following information and bring to your first session. Please note: information you provide here is protected as confidential information.

CLIENT INFORMATION:

Name (first and last): ______________________________________ Date: ___ / ___ / ___

Identified Sex: _______________ Date of Birth: ____ / ____ / ____ Age: _______

Mailing Address: ____

Email Address: ____
Is it okay to send email to this address? Yes No

Phone: Home ________________________ Okay to leave message? Yes No
Work ________________________ Okay to leave message? Yes No
Mobile ________________________ Okay to leave message? Yes No

Marital status: ___ single ___ married ___ partnered
___ separated ___ divorced ___ widowed

Number of children: ________ Ages of children: _______________

Ethnicity: ___________________________ Religion: ________________________

Occupation: _________________________ Employer/School: __________________

Emergency contact name: ____
Relationship to client: ____
Emergency contact number: ____

How did you hear about Kate Sproul Counseling? __________________________

STATEMENT OF NEED:

Please provide a brief description of your reasons for seeking counseling at this time:

Please circle or underline any of the following that pertain to you:

Anxiety	Suicidal Thoughts	Career Choices	Spirituality Concerns
Sexual Concerns	Drug/Alcohol Use	Sleep Changes	Life Transitions
Finances	Feelings of Insecurity	Cutting/Self-Harm	Grief and Loss
Self-Control	Abuse	Trauma	Disordered Eating
Work Stress	Worry/Fear	Relationships	Health Concerns
Depression	Separation/Divorce	Anger	Other: ____________

HEALTH INFORMATION:

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

If *yes*, then please list: ____

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

If *yes*, then please list and provide dates of use: ______________________________

____

How many alcoholic beverages do you consume per week? ________________________

List recreational drugs used within last 6 months (type and frequency of use): ____________

____

How many times per week do you generally exercise? ____________________________

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

Poor Unsatisfactory Satisfactory Good Very Good

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

____

Have you previously received mental health services? **Yes** **No**
(psychotherapy, psychiatric care, drug or alcohol treatment etc.)
If *yes,* please provide provider's name: ______________________________
Reason you sought services: ______________________________
What was most helpful? ______________________________
What was least helpful? ______________________________

Any psychiatric hospitalizations? **Yes** **No**
If *yes,* please provide some detail: ______________________________
____
____

Have you ever attempted or considered suicide? **Yes** **No**
If *yes,* please provide some detail: ______________________________
____
____

Do you currently feel suicidal, or do you currently experience unwanted thoughts of wanting to end your life? **Yes** **No**
If *yes,* please provide some detail: ______________________________
____
____

FAMILY MENTAL HEALTH HISTORY:
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.

		List Family Member
Alcohol/Substance Abuse	Yes / No	____________
Anxiety	Yes / No	____________
Depression	Yes / No	____________
Domestic Violence	Yes / No	____________
Eating Disorders	Yes / No	____________
Obesity	Yes / No	____________
Obsessive Compulsive Disorder	Yes / No	____________
Schizophrenia	Yes / No	____________
Suicide Attempts	Yes / No	____________

ADDITIONAL INFORMATION:

Do you consider yourself to be spiritual or religious? If *yes,* please describe your faith or belief:

What do you consider to be some of your strengths?

What would you like to accomplish out of your time in therapy?

Any other information you would like me to know?

Client Signature: ______________________________ Date: _______________

Clinician: ___________________________________ Date: _______________

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