Penelope Chui
Licensed Marriage & Family Therapist
Licensed Professional Clinical Counselor

NEW CLIENT INTAKE FORM

Today's Date:_____ Referred by _____

Name:_____ Date & place of Birth _____

Social Security #: _____ Sex: Male ___ Female ___

Street Address:_____

City, State, Zip:_____

May I have permission to mail to this address? Yes ___ No ___

Home Phone: _____ Work Phone: _____

Cell Phone: _____

For Routine Messages Phone # _____

For Confidential/ Private Message Phone # _____

Marital Status: Single ___ Cohabitating ___ Married ___ Divorced ___ Widowed ___

Children: Yes ___ No ___ If yes, custody status:_____

Children or others living in the home: _____ Age:____

_____ Age:____

_____ Age:____

_____ Age:____

Children living outside the home _____ Age:____

_____ Age:____

_____ Age:____

Occupation:_____ How long in this occupation? _____

Employer Name: _____ School Name: _____

Education: (List highest level of education attained)_____

Emergency Contact: Name, relationship and phone # _____

CLIENT NAME:_____ **DATE**:_____

Please describe your overall health today and list any significant health problems:

_____

_____

List any medications you are taking, the dosage and prescribing physician:

_____

_____

Are any of these medications for mental/emotional problems?

Name of your primary physician: _____ Date of most recent visit _____

Past/Present drug/alcohol use/ abuse/treatment (any addiction) _____

_____

Prior suicide attempts? Yes ___ No___ If Yes, when? _____
Circumstances that led to the attempt:

_____

_____

Current suicidal thoughts? Yes ___ No ___
If yes, please describe: _____

_____

Prior outpatient therapy? Yes ___ No ___
If yes, with whom, when and for how long?

_____

What was the focus of the previous treatment?

_____

How was it helpful? _____

_____

Prior hospitalization for mental/emotional problems? _____Yes _____No
If yes, please describe (year/duration/reason for hospitalization):

_____

Family history of alcoholism, substance use, mental illness, violence, suicide:_____

When you feel uncomfortable to answer any question, feel free to skip them. Use the space on the back of this form when you need to give further information.

CLIENT NAME:_____ **DATE**:_____

CURRENT CONCERNS CHECKLIST (Rate intensity of concerns currently present)
□**None** -- This concern not currently present
□**Mild** -- Impacts quality of life, but no significant impairment on daily functioning
□**Moderate** -- Significant impact on quality of life and daily functioning
□**Severe** -- Profound impact on quality of life and daily functioning

	None	Mild	Moderate	Severe
Depressed Mood	□	□	□	□
Sleep Disturbance	□	□	□	□
Appetite Disturbance	□	□	□	□
Low Energy/Fatigue	□	□	□	□
Poor Concentration	□	□	□	□
Hopelessness	□	□	□	□
Worthlessness	□	□	□	□
Social Isolation	□	□	□	□
Excessive Worries	□	□	□	□
Irritability	□	□	□	□
Anxious	□	□	□	□
Mood Swings	□	□	□	□
Elevated Mood	□	□	□	□
Racing Thoughts	□	□	□	□
Hypervigilance	□	□	□	□
Hyperactivity	□	□	□	□
Panic Attacks	□	□	□	□
Impulsive Behaviors	□	□	□	□
Aggressive Behaviors	□	□	□	□
Phobias	□	□	□	□
Obsessions/Compulsions	□	□	□	□
Weight Gain/Loss	□	□	□	□
Anorexia	□	□	□	□
Bingeing/Purging	□	□	□	□
Self Mutilating Behaviors	□	□	□	□
Delusions	□	□	□	□
Hallucinations	□	□	□	□
Grief	□	□	□	□
Financial Problems	□	□	□	□
Sexual Problems	□	□	□	□
Marital Difficulties	□	□	□	□
Family Conflicts	□	□	□	□
Difficulty Making Friends	□	□	□	□
Difficulty Keeping Friends	□	□	□	□

CLIENT NAME:_____ **DATE**:_____

What do you consider to be your strengths: _____

_____

_____

_____

What do you like most about yourself: _____

_____

_____

What are your most important hopes and dreams? _____

_____

What are your main worries and fears? _____

_____

What brings you into therapy today? _____

_____

When did the issue arise? _____

_____

What are your goals of therapy? _____

_____

_____