Tucson Counseling Associates, LLC

NEW CLIENT INTAKE

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Preferred Name: (if different): _____

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender Identity: _____

Relationship status/orientation:_____

Please list any children/age:
_____
_____

Address: _____

Home phone: ( ) May we leave a message? _____
Cell/other: ( ) May we leave a message? _____
Text message preferred? _____

Email: _____ May we email you? _____
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Emergency name and contact info: _____
Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- ☐ No
- ☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medications?

- ☐ Yes
- ☐ No

Please list:

_____

_____

Have you ever been prescribed psychiatric medications?

- ☐ Yes
- ☐ No

Please list:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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

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5. Are you currently experiencing overwhelming sadness, grief, or depression?

- ☐ No
- ☐ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any specific phobias?

- No
- Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes,, please describe: _____

8. How much alcohol do you drink? _____ Drinks per _____(day/week/month)

9. How often do you engage in recreational drug use? (please circle)

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? _____

If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of the following.

	Please Circle	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 Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	

ADDITIONAL INFORMATION:

1. What significant life changes or stressful events have you experienced recently?

_____
_____
_____
_____

2. Are you currently employed? _____

If yes, what is your current employment situation?
_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

3. Do you consider yourself to be spiritual or religious? _____

If yes, please describe your faith or belief:
_____

4. What do you consider to be some of your strengths?
_____
_____
_____
_____

5. What do you consider to be some of your weaknesses?
_____
_____
_____
_____

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