

# NEW CLIENT INTAKE FORM



Welcome to Rekindle Counseling. These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

### CLIENT INFORMATION

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Parent/Guardian(s) (if under 18): \_\_\_\_\_

Phone (h): \_\_\_\_\_ Messages ok at home? Yes No

Phone (cell): \_\_\_\_\_ Messages ok on cell? Yes No

Phone (w): \_\_\_\_\_ Messages ok at work? Yes No

Email: \_\_\_\_\_ Emails ok? Yes No

(Note: I cannot guarantee the confidentiality of email.)

(Please circle) Male Female Other \_\_\_\_\_

(Please circle all that apply)

Single \_\_\_\_\_ Cohabiting (how long?) \_\_\_\_\_

Engaged (date) \_\_\_\_\_ Married (date) \_\_\_\_\_

Divorced (date) \_\_\_\_\_ Separated (date) \_\_\_\_\_

Previously Married (year of marriage/year of divorce) \_\_\_\_\_

Other (please describe) \_\_\_\_\_

Who currently lives with you? \_\_\_\_\_

Other children's names and ages: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Ethnic/Cultural Heritage: \_\_\_\_\_

How did you find out about Rekindle Counseling? \_\_\_\_\_

**PERSONAL STRENGTHS**

What do you do well and what activities do you enjoy?

What personal qualities would others say you have?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

**COUNSELING/MEDICAL HISTORY**

Have you previously seen a counselor? Yes No

Name of any therapist(s) currently being seen: \_\_\_\_\_

Approximate Dates of Counseling:

For what reason?

Was it helpful?

Have you used psychiatric services? Yes No Was it helpful? Yes No

Please describe.

Have you taken medication for a mental health concern? Yes No

Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe.

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

## FOR COUPLES COUNSELING

Please check any couple concerns that you are having.

- |   |  |
|---|--|
| <input type="checkbox"/> Fighting _____         | <input type="checkbox"/> Disagreeing about Relatives _____ |
| <input type="checkbox"/> Feeling Distant _____  | <input type="checkbox"/> Disagreeing about Friends _____   |
| <input type="checkbox"/> Loss of fun _____      | <input type="checkbox"/> Alcohol Use _____                 |
| <input type="checkbox"/> Sexual concerns _____  | <input type="checkbox"/> Drug Use _____                    |
| <input type="checkbox"/> Violence _____         | <input type="checkbox"/> Infidelity _____                  |
| <input type="checkbox"/> Lack of Intimacy _____ | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Money _____            | <input type="checkbox"/> Other _____                       |

Comments:

## INDIVIDUAL CONCERNS

Please check any personal concerns that you are having:

- |  |  |
|--|--|
| <input type="checkbox"/> Sadness _____           | <input type="checkbox"/> Hurting self _____          |
| <input type="checkbox"/> Crying _____            | <input type="checkbox"/> Hurting others _____        |
| <input type="checkbox"/> Irritability _____      | <input type="checkbox"/> Anger/Rage _____            |
| <input type="checkbox"/> Loss of pleasure _____  | <input type="checkbox"/> Abuse (childhood) _____     |
| <input type="checkbox"/> Sleep problems _____    | <input type="checkbox"/> Abuse (adult) _____         |
| <input type="checkbox"/> Eating problems _____   | <input type="checkbox"/> Distractible _____          |
| <input type="checkbox"/> Hopelessness _____      | <input type="checkbox"/> Hearing things _____        |
| <input type="checkbox"/> Guilt _____             | <input type="checkbox"/> Seeing things _____         |
| <input type="checkbox"/> Mood swings _____       | <input type="checkbox"/> Loneliness _____            |
| <input type="checkbox"/> Fear _____              | <input type="checkbox"/> Grief/loss _____            |
| <input type="checkbox"/> Nightmares _____        | <input type="checkbox"/> Work issues _____           |
| <input type="checkbox"/> Flashbacks _____        | <input type="checkbox"/> Spirituality issues _____   |
| <input type="checkbox"/> Obsessions _____        | <input type="checkbox"/> Alcohol Use _____           |
| <input type="checkbox"/> Anxiety _____           | <input type="checkbox"/> Another's Alcohol Use _____ |
| <input type="checkbox"/> Panic _____             | <input type="checkbox"/> Drug Use _____              |
| <input type="checkbox"/> Suicidal thoughts _____ | <input type="checkbox"/> Another's Drug Use _____    |
| <input type="checkbox"/> Suicidal acts _____     | <input type="checkbox"/> Other _____                 |

Comments:

**ADDITIONAL INFORMATION** Is there anything else you would like to share?

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_