CHANGE-WELL

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New Client Intake Form

Personal Information

Today's Date: _____ Age: _____ Gender: _____

Name: _____ Date of Birth: _____/_____/_____

Parent/Legal Guardian (if under 18): _____Text_____

Address: _____
Street City State Zip

Home Phone: _____ May I leave a message? ☐ Yes ☐ No
Mobile Phone: _____ May I leave a message? ☐ Yes ☐ No
Email: _____ May I leave a message? ☐ Yes ☐ No

Education: _____ Occupation: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Closest Relationships:

Name	Relationship	Age	Do they live with you?
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement:

_____

Emergency Contact: _____ _____
Name, Relationship Phone Number

Address:

_____
Street City State Zip

Referred By (if any): _____

History

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 medication? ☐ No ☐ Yes - If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes - If yes, please list and provide dates:

_____ _____

_____ _____

Primary Care Physician: _____ _____

Name Phone

General and Mental Health Information

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

☐ 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 one)

☐ 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, and what do you do for exercise?

_____

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

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 phobias?

☐ No ☐ Yes - If yes, when did you begin experiencing this? _____

7. Are you currently experiencing chronic pain? ☐ No ☐ Yes - If yes, please describe:

_____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. Do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes - If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? Why?

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

_____

_____

_____

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 relationship to you: (i.e. mother, brother, uncle, etc.)

Mental Issue	**Please Circle**	**Family Member(s)**
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. Are you currently employed? ☐ No ☐ Yes – If yes, what is your current employment?

_____

Do you enjoy your work? _____

Is there anything stressful about your current work? _____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief:

_____

3. How can I help? In your own words what brings you here today?

_____

_____

4. What are your two most important goals for therapy?

1. _____
2. _____

5. Is there anything else you'd like me to know?