New Client Intake
Hannah Sholar MA, PLPC

Client Information

BASIC INFORMATION

Name: ____ Date of Birth____________________

Address: ____

Please provide contact phone number(s) and indicate your preferred number.

Home Phone: _______________Leave a message? ___ yes ___ no preferred? ___ yes ___ no

Cell Phone: _______________ Leave a message? ___ yes ___ no preferred? ___ yes ___ no

Work Phone: _______________ Leave a message? ___ yes ___ no OK to call? ___ yes ___ no

E-mail:________________________ OK to E-mail? ___ yes ___ no

Referred by: ______________________________

Do I have your permission to thank the person who referred you? ___ yes ___ no

RELIGIOUS AND SPIRITUAL

Do you consider yourself spiritual? Yes ___ No ___ religious? Yes ___ No ___

Comment? ____

Do you currently express this spirituality through religious practice? Yes No

Comment? ____

Would you like spirituality included in your counseling? Yes ___ No ___

BACKGROUND AND PRESENTING PROBLEM

Occupation (s) ____

Marital Status _____ If married, how long? ______

If you have been married before, please provide dates for marriage(s) and divorce(s):

____

Please briefly describe the problem or situation, which led you to seek services at this time:

How long has this been an issue? ____________

Have you experienced this type of issue before? __________ If so, when?________________

Have you ever had counseling before? Yes_____No_____If so, when?__________________

Was it helpful? Yes_____No_____ If not, why not?

____

____

Presenting problems: (check all that apply)

- ☐ very unhappy
- ☐ irritable
- ☐ temper outbursts
- ☐ withdrawn
- ☐ daydreaming
- ☐ fearful
- ☐ worry
- ☐ overactive
- ☐ slow
- ☐ short attention span
- ☐ distractible
- ☐ lacks initiative
- ☐ undependable
- ☐ social problems
- ☐ crying spells
- ☐ hair pulling
- ☐ impulsive
- ☐ Stubborn
- ☐ panic attacks
- ☐ lying
- ☐ mean to others
- ☐ destructive
- ☐ trouble with the law
- ☐ health problems
- ☐ self-mutilating
- ☐ stressed out
- ☐ relationship problems
- ☐ shy

- ☐ strange behavior
- ☐ strange thoughts
- ☐ physical abuse
- ☐ sexual abuse
- ☐ parenting problems
- ☐ Stealing
- ☐ repetitive/ritualistic behaviors
- ☐ grief
- ☐ employment problems
- ☐ financial stress
- ☐ legal problems
- ☐ violence
- ☐ eating problems
- ☐ sleeping problems
- ☐ sexual problems
- ☐ drug use
- ☐ alcohol use
- ☐ suicidal thoughts
- ☐ homicidal though

Explain:

Do you have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? ___ yes ___ no

If so, which relatives and what kind of problems?

Have you experienced any health problems in last 6 months?

- ☐ tremors
- ☐ dizziness/fainting
- ☐ seizures
- ☐ alcohol use
- ☐ drug use
- ☐ tobacco use
- ☐ chest pain
- ☐ weight loss/weight gain
- ☐ compulsive dieting
- ☐ stomach discomfort
- ☐ vomiting
- ☐ muscle spasms
- ☐ sexual difficulties
- ☐ back pain
- ☐ headaches
- ☐ blackouts
- ☐ hypertension
- ☐ numbness
- ☐ impaired vision
- ☐ pregnancy

Any hospitalizations:

Do you have any current medical diagnoses: ___ yes ___ no

If yes please describe:____
Are you taking any prescription medications? ___ yes ___ no
If so, please list prescribing physician and medication type:

Physician:______________________________ Phone:______________________

Medication:__________________________________ Dose:_____________ Start Date:_________

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What are your goals for therapy?

Is there anything else you feel is important for your counselor to know?