Frederick Counseling LLC
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New Patient Intake Form

Name: ____
Last First Middle Name you wish to be called

Age: ___ Date of Birth: ____/____/______ Cell: ___________________Other Phone:__________
month/day/year

Address:_____________________________________ Email:__________________________________
Street/ PO Box

____
City State Zip

Referred by: ____Today's Date: __/__/___
Name Relationship month/day/year

Relationship Status: __Single __ Partnered __Married ___Divorced ____Seperated ___Widowed

Living Situation (Location, Names & Relationships of Who You Live With): __________________

____

Occupation & Employer ____

Emergency Contact:
Name: __________________________ Phone:___________________ Relationship_________

Identity
Sex/Gender:_______________________ Sexual Orientation__________________________________
Race/Racial Identity:___________________Religion/Spiritual Identity_______________________
Current Hobbies or Interests:____
Describe your health:____
Why are you seeking help? (Brief description):____

____

Psychological and Behavioral Symptoms: (Check all that apply)

- ❑ Crying Spells
- ❑ Loss of interest in activities
- ❑ Anger issues
- ❑ Problems with sleep
- ❑ Problems with appetite
- ❑ Hopelessness/helplessness
- ❑ Mood swings
- ❑ Thoughts of dying/suicide
- ❑ Injury/acts of self harm
- ❑ Thoughts of wanting to kill/homicide
- ❑ Physical fatigue or discomfort
- ❑ Arguments with family/partner/coworkers
- ❑ Facing possible marital separation/divorce
- ❑ Sexual Problems
- ❑ Worried thoughts
- ❑ Panic attacks (racing heart rate, feeling of impending doom)
- ❑ Phobias (intense fears of specific events or things
- ❑ Flashbacks of terrible events
- ❑ Feeling "on top of the world" or "I can do anything"
- ❑ Difficulty accepting changes
- ❑ Self-esteem changes
- ❑ Using alcohol or drugs to cope
- ❑ Other symptoms or changes in functioning:________________________________

Psychological History:

Have you received previous Psychotherapy/Counseling/Psychological Help? ___Yes ___No

Therapist Name________________________________Phone:________________

Address:____

Duration of Treatment:____

Type of Counseling:___ Individual ___Family ___Couples

Outcome/Helpfulness:____

Therapist Name________________________________Phone:________________

Address:____

Duration of Treatment:____

Type of Counseling:___ Individual ___Family ___Couples

Please note treatment location, duration and outcome/helpfulness when relevant

Inpatient and/or Partial Hospitalization:____

Substance Abuse Treatment:____

Suicide Attempts:____

Family history of suspected or diagnosed mental health issues: __________________

History of medications for psychological symptoms:_____________________________

____

What medication are you currently taking?

Name	Dosage	Condition
____________________	______	________________________
____________________	______	________________________
____________________	______	________________________
____________________	______	________________________
____________________	______	________________________

Physical History:

Most recent physical:___/___/_____ Physician________________________ Ph:______________

Please describe any noteworthy physical conditions:________________________________

____

History of medical problems/surgeries:____

____

Allergies:____

____

Family/Childhood History

Family:	**Name**	**Age**	**Occupation**	**Health (Mental & Physical) Notes**
Father:	____________	____	________	________________
Mother:	____________	____	________	________________
Step-Father:	____________	____	________	________________
Step-Mother:	____________	____	________	________________
Brothers/Sisters:	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________
Spouse/Partner:	____________	____	________	________________
	____________	____	________	________________
Children:	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________
	____________	____	________	________________

Where did you grow up?:____

Who raised patient?:____

Developmental delays? (sitting up, walking, talking, speech problems?):____________________

____

History of physical abuse or neglect?:____

Domestic conflicts or violence in the home?:____

History of sexual abuse or rape/assault?:____

History of verbal abuse or bullying?:____

Legal history or use of a weapon?:____

Education

Highest level of schooling completed:__High School Graduate ___College ___PostGrad

Currently in School?:_________ If so, where?:____

Chemical Use History

Drug	Age at First Use	Date of most recent use	Current amount per sitting
Caffeine			
Nicotine			
Alcohol			
Marijuana			
Prescription or OTC Drugs			
Other/Describe:			

Describe family substance use/abuse history:____

____

____

Want to cut down on drinking/drug/pill use? _____Yes _____No

Anyone ever express concern about your alcohol or drug use?_____Yes _____No

Goal(s) for Treatment: 1:____

2:____

Date Form Completed: ___/___/______Printed Name of Patient:______________________________

Patient Signature:______________________________