Penelope Chui
Licensed Marriage & Family Therapist
Licensed Professional Clinical Counselor

NEW CLIENT INTAKE FORM

Today's Date: ________________________ Referred by ________________________________

Name: _____________________________________ Date & place of Birth _________________

Social Security #: ___________________________ Sex: Male ___ Female ___

Street Address:
____

City, State, Zip: ____

May I have permission to mail to this address? Yes ___ No ___

Home Phone: _____________________ Work Phone: _____________________

Cell Phone: _____________________

For Routine Messages Phone # ________________________

For Confidential/ Private Message Phone # _____________________

Marital Status: Single ___ Cohabitating ___ Married ___ Divorced ___ Widowed ___

Parents or legal guardian Name: ____

Parents, siblings or others living in the home: ______________________________ Age:____

______________________________ Age:____

______________________________ Age:____

______________________________ Age:____

Parents or siblings living outside the home ______________________________ Age:____

______________________________ Age: ____

Occupation:__________________________________ How long in this occupation? __________

Employer Name: ___________________________ School Name: __________________________

Grade: ______ GPA/Performance: ____

Emergency Contact: Name, relationship and phone # ____________________________________

CLIENT NAME:________________________________ **DATE**:______________

Please describe minor's overall health today and list any significant health problems:

____

____

List any medications the minor is taking, the dosage and prescribing physician:

____

____

Are any of these medications for mental/emotional problems?

Name of primary physician: _______________ Date of most recent visit _________

Past/Present drug/alcohol use/ abuse/treatment (any addiction) __________________________

____

Prior suicide attempts? Yes ___ No___ If Yes, when? ________________________________
Circumstances that led to the attempt:
____

____

Current suicidal thoughts? Yes ___ No ___
If yes, please describe: ____

____

Prior outpatient therapy? Yes ___ No ___
If yes, with whom, when and for how long?
____
What was the focus of the previous treatment?

____
How was it helpful? ____

____
Prior hospitalization for mental/emotional problems? _______Yes _______No
If yes, please describe (year/duration/reason for hospitalization):
____

Family history of alcoholism, substance use, mental illness, violence, suicide:____

CLIENT NAME:_________________________________ **DATE**:______________

PRENATAL/DEVELOPMENTAL HISTORY OF MINOR

Problems during pregnancy or delivery of minor? _______________________________
____

Any use of drugs or alcohol during pregnancy of minor? __________________________
____

Congenital defects? (If yes, specify) ____
____

Age at which minor:
Sat Up ________ Crawled ________ Stood alone ________
Walked ______ First Words ______

Age at which potty-trained _______ Length of time to train _________

Soiling or bedwetting? ____

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness or injury:
____
____
____

List any prolonged separation or traumatic events in childhood
____
____
____

When you feel uncomfortable to answer any question, feel free to skip them. Use the space on the back of this form when you need to give further information.

CLIENT NAME:________________________________ **DATE:**______________

CURRENT CONCERNS CHECKLIST (Rate intensity of concerns currently present)

☐**None** -- This concern not currently present
☐**Mild** -- Impacts quality of life, but no significant impairment on daily functioning
☐**Moderate** -- Significant impact on quality of life and daily functioning
☐**Severe** -- Profound impact on quality of life and daily functioning

	None	Mild	Moderate	Severe
Depressed Mood	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐
Low Energy/Fatigue	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐
Excessive Worries	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Anxious	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐
Racing Thoughts	☐	☐	☐	☐
Hypervigilance	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐
Impulsive Behaviors	☐	☐	☐	☐
Aggressive Behaviors	☐	☐	☐	☐
Phobias	☐	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐
Bingeing/Purging	☐	☐	☐	☐
Self Mutilating Behaviors	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Grief	☐	☐	☐	☐
Financial Problems	☐	☐	☐	☐
Sexual Problems	☐	☐	☐	☐
Marital Difficulties	☐	☐	☐	☐
Family Conflicts	☐	☐	☐	☐
Difficulty Making Friends	☐	☐	☐	☐
Difficulty Keeping Friends	☐	☐	☐	☐

CLIENT NAME:________________________________ **DATE**:______________

What do you consider to be your strengths?___________________________________

____

____

____

What do you like most about yourself? ______________________________________

____

____

What are your most important hopes and dreams? ______________________________

____

What are your main worries and fears? ______________________________________

____

What brings you into therapy today? _______________________________________

____

When did the issue arise? ____

____

What are your goals for therapy? ____

____

____