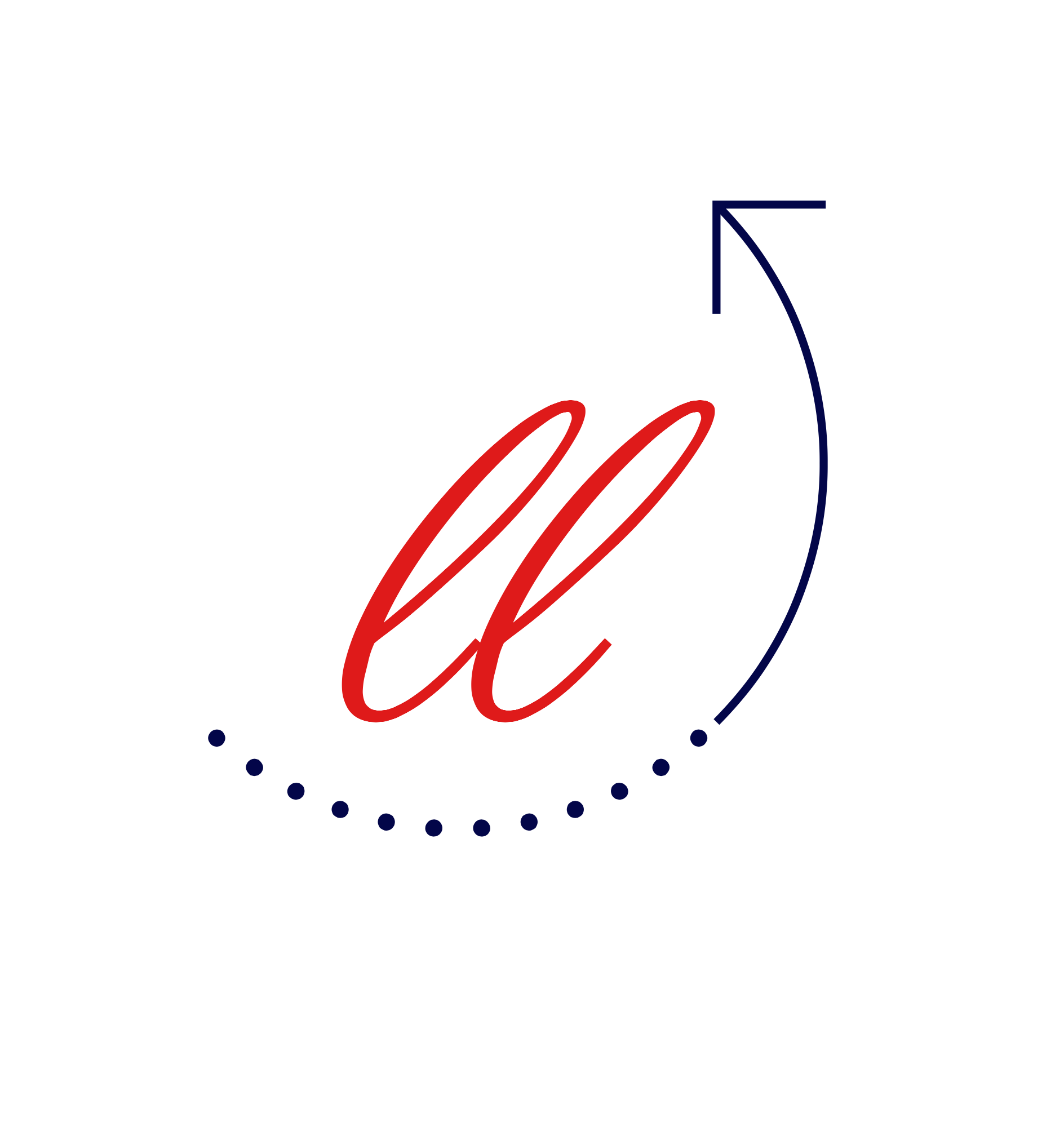
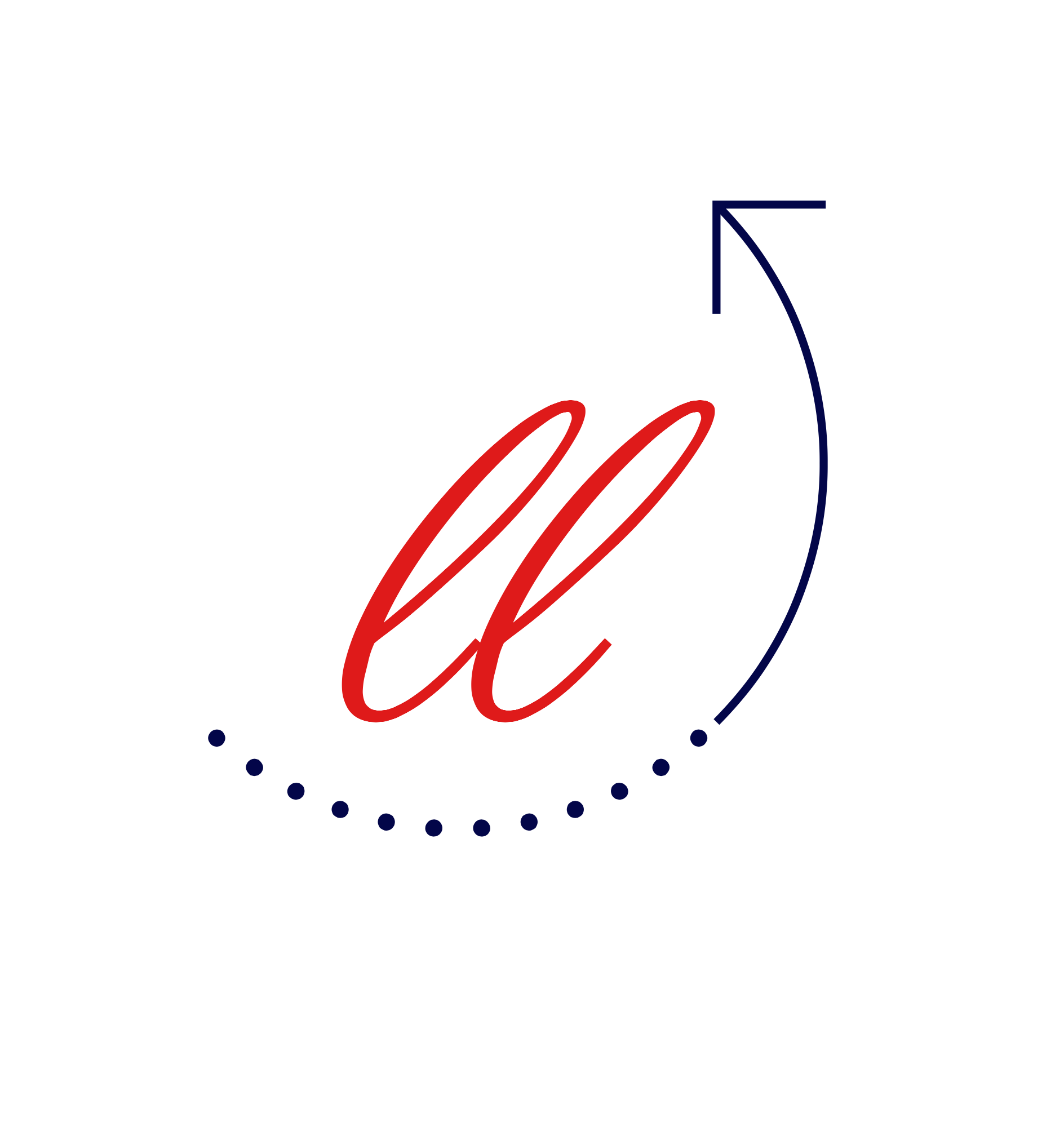
NEW CLIENT INTAKE FORM

**

Laura Lindekugel M.S., M.S.

Rekindle Counseling

*Welcome. Please complete this form and bring it to your first appointment. Thank your for your time in doing so.. I look forward to meeting with you and to working together to reach your goals.*

**NEW CLIENT INFORMATION**

***Personal Information***

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip code\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to email Yes☐ No☐ Secondary email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to email Yes☐ No☐ Primary phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to leave message Yes☐ No☐Secondary phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to leave message Yes☐ No☐Preferred method(s) of contact primary email☐ secondary email☐ primary phone ☐secondary phone Emergency contactname/phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_Permission to contact Yes☐No☐ Permission to leave message Yes☐ No☐ Parent/Guardian(s) (if under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_\_ Preferred pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religious affiliation or spiritual practice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Important to you Yes☐ No☐Ethnic/cultural heritage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Important to you Yes☐ No☐

***Counseling + Medical History***

Have you previously seen a therapist? Yes☐ No☐ Was it helpful? Yes☐ No☐

What forms of psychotherapy and/or bodywork have you explored?

Type/Issues addressed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration/Context for termination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type/Issues addressed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration/Context for termination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any negative experiences in therapy? Yes☐ No☐

Have you ended any therapeutic relationships without a clear sense of closure? Yes☐ No☐

Name(s) of any therapist(s) currently being seen

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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☐ Was it helpful? Yes☐ No☐

Are you currently taking medication for a mental health concern Yes☐ No☐ Helpful? Yes☐ No☐

Please list any current medications/herbal, homeopathic, or nutritional supplements that you use on a regular basis, who prescribed them, for what condition(s), + side effects you are aware of.

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Is anyone monitoring your medication? Yes☐ No☐

Are you being treated currently for any medical concern(s)? Yes☐ No☐

Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have other medical concerns or previous hospitalization, major illnesses, injuries, or surgeries? Yes☐ No☐ Please describe + list years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Individual Concerns***

Please check all that apply: Sadness☐ Crying☐ Irritability☐ Loss of pleasure☐ Sleep problems☐ Eating problems☐ Hopelessness☐ Guilt☐ Shame☐ Mood swings☐ Fear☐ Nightmares☐ Flashbacks☐ Intrusive thoughts☐ Obsessions☐ Avoidance☐ Anxiety☐ Panic☐ Suicidal thoughts☐ Suicidal acts☐ Hurting self☐ Hurting others☐ Anger/Rage☐ Abuse (childhood)☐ Abuse (adult)☐ Distractibility☐ Difficulty concentrating☐ Loneliness☐ Grief/loss☐ Work issues☐ Spirituality issues☐ Alcohol Use☐ Another’s alcohol use☐ Drug use☐ Another’s drug use☐ Shift in sex drive or low sex drive☐ Weight change☐ Body pains☐ Isolation☐ Resentment☐ Indigestion☐ Muscle tightness☐ Tiredness☐ Bowel changes or distress☐ Stomachaches☐ Dizziness☐ Intolerance☐ Shutting down☐ Withdrawal☐ Difficulty forming relationships☐ Difficulty trusting others☐ Difficulty identifying/feeling/expressing emotions☐ Working too hard to please others☐ Difficulty forming lasting relationships☐ Engaging in sexual behavior that you don't like☐ Compulsive behaviors☐ Family conflict☐ Conflict with friends☐ Feeling that others take advantage of you☐ Feeling you are too dependent on others☐ Fearing disappointing others☐ Difficulty committing to relationship(s) ☐ Hyper-criticalness☐ Procrastination☐ Indecisiveness☐ Feeling helpless☐ Feeling unhappy without reason☐ Excessive self-sacrificing☐ Loss of life direction☐ Other☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Couple Concerns***

Please check all that apply: Fighting☐ Feeling Distant☐ Loss of fun☐ Alcohol Use☐ (my use☐ partner’s use☐) Drug use (my use☐ partner’s use☐) Disagreeing about Relatives☐ Disagreeing about Friends☐ Sexual concerns ☐ Violence☐ Lack of Intimacy☐ Money☐ Infidelity (me☐ partner☐) Other☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Current Functioning***

What prompted you to seek therapy at this time?

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What are your current coping mechanisms? How do you currently manage stress in your life?

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Are you currently using alcohol, drugs, tobacco, food, work, sex, or money in an addictive way? What are your current patterns of use with anything you use to help with your mood? Concerned? Yes☐ No☐

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If you had addictive use in the past, when was that? Have you addressed this in treatment, therapy, or support groups? Yes☐ No☐ How and when?

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Have you ever been suicidal or attempted suicide? Yes☐ No☐ Have you engaged in self-injurious behavior? Yes☐ No☐

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***Relationship Information***

Current relationship status: Single☐ Dating☐ Cohabitating☐ Engaged☐ Married☐ Separated☐ Divorced☐ Previously Married☐ Partner or spouse deceased☐ Other☐

Please list the names, ages, and relationships of those with whom you currently live. Please indicate whether any children live with you full-time or part-time.

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Are you engaged in any relationships you experience as abusive? Yes☐ No☐ How are these relationships abusive?

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***Personal Strengths***

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

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What personal qualities would others say you have?

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***Goals***

What do you want to accomplish in our work together?

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What is your primary goal for this appointment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the major symptoms or difficulties that you want to address in our work together?

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Do you have any resistance, fears, or questions you are aware of entering our work together?

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***Additional Information***

Is there anything else you would like me to know?

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***Referral Information***

How did you find out about Laura? Rekindle website☐ Therapymplsmn website☐ Personal referral☐

Name of referring person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician☐ Therapist☐ Friend☐ Relative☐ Co-worker☐ Other☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Client Signature***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Parent/Guardian Signature (for clients under 18)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_