NEW CLIENT INTAKE FORM

**

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Rekindle Counseling

*Welcome. Please complete this form and bring it to your first appointment. Thank your for your time in doing so. I ask for a lot of information. The responses you provide will help us to begin our work more efficiently and effectively. I look forward to meeting with you and to working together to reach your goals.*

**NEW CLIENT INFORMATION**

***Personal Information***

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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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☐Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is the highest level of education that you completed? High school☐ Post-high school certificate☐ Trade school☐ AA Degree☐ Four-year college degree☐ Masters degree☐ PhD☐ JD☐ MD☐

Degree(s)/training\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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

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Have you used psychiatric services? Yes☐ No☐ Was it helpful Yes☐ No☐

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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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Do you have any recent injuries or body traumas? Yes☐ No☐

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

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Do you have any chronic physical conditions or discomfort? Yes☐ No☐

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

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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☐ Hearing things☐ Seeing things☐ 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☐ Difficult 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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Are you experiencing any recent changes, such as change in work, relationship, living conditions, or health?

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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☐

Names of significant partners + dates of cohabitation, engagement(s), marriage(s), separation(s) divorce(s), loss of partner(s)/spouse(s)

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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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How do you feel about your current living situation?

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***Lifestyle***

What is your current work? How do you feel about your work life?

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What other parts of your life are currently active (creativity, spirituality, community service, recreation)?

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Do you exercise regularly? What kind of exercise do you do? Important to you? Yes☐ No☐

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How much caffeine do you use? Throughout the day☐ Moderate☐ Seldom☐ Never☐

Briefly describe your eating habits. Is your diet important to you? Yes☐ No☐

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Please check all that apply: Vegetarian☐ Vegan☐ Pescetarian☐ Paleo☐ Organic ☐ Fast food☐ Cook meals☐ Ready made/packaged meals or food☐ Skip meals☐ Restrict☐ Binge☐ Dieting☐

How do you feel about your support system overall? Positive☐ Neutral☐ Negative☐

Who do you confide in, or rely on?

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***Developmental History***

What do you know, either factually or intuitively, about your conception, and your mother’s pregnancy with you (for example, family circumstances, feelings of parents, injuries or stresses to your mother)? What about your birth?

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Please list the members of your family of origin, their dates of birth (and death) and significant issues they have had. Please include all of your parents’ abortions, miscarriages, still births, and adoptions.

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Please describe the emotional atmosphere in the household in which you were raised (for example, calm, loving, supportive, chaotic, abusive, violent, unpredictable, etc.).

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Did you ever experience physical, sexual, emotional, and/or verbal abuse in your past? If so, please indicate when and what relationship, if any, the perpetrator of the abuse had to you.

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Please describe your family’s cultural and economic background, and where you lived.

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How did you feel growing up in your family? How did you try to feel successful? How did you cope with difficulties?

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Were there any outstanding events in your family as you were growing up (for example, deaths, moves, job loss, divorce)? How did you and your family respond?

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Describe each of your caregivers in terms of both what you appreciated about that person, and what you found difficult.

Mother

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Father

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Other significant caregivers (sibling, relative, nanny, neighbor)

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Have you witnessed the abuse of others? Have you initiated or participated in abusing another?

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What aspects of your family life do you find yourself playing out now (both those that enhance your life, and those that are problematic)?

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Have you had any significant traumas while growing up, or as an adult (assaults, accidents, untimely deaths, etc.)?

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Which emotions do you feel relatively easily? Which emotions are more difficult for you to access or express?

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Are you satisfied with your current sexual expression? Are there aspects of your sexuality that you want to heal or explore in therapy?

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Have you ever been pregnant or impregnated someone? Describe briefly the outcome (birth, miscarriage, abortion), and what this experience was like for you. Do you feel resolved about the experience?

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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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Who are some of the influential and supportive people, activities, or beliefs in your life?

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***Goals***

Do you have any dreams or goals for five or ten years from now? What are they?

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If you were 90 years old and looking back on your life, what would you want to say?

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If you could change one thing that would have a positive impact on your life, what would that be?

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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? Ad☐ Mailing☐ Web search☐ Rekindle website☐ Partners in Healing website☐ Personal referral☐

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

***Client Signature***

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

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