New Leaf Therapy, LLC
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Adult Intake Information

Please fill out this form and bring it to your first session.

Name _____ Date_____

Preferred First Name_____

DOB_____ Age_____ Sex_____ SSN_____

Marital Status: ☐ Single ☐ Co-habitating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address_____ _____ _____ _____
Street City State Zip Code

Home Phone _____ Is it ok to leave a message? _____ *(Y/N)*

Cell Phone_____ Is it ok to leave a voice mail? _____ *(Y/N)*

Is it ok to send a text? _____ *(Y/N)*

Email_____ Is it ok to send an email? _____ *(Y/N)*

Check your preferred contact method(s): ☐ Home phone ☐ Cell Phone ☐ Text ☐ Email

Emergency Contact_____ _____ _____
Name Relationship Phone

Family Physician_____ _____
Name Phone

Employer/School_____

Occupation_____ ☐ *Full-Time* ☐ *Part-Time* ☐ *Student* ☐ *Retired*

Partner's Name_____ Partner's DOB_____

Please list names and ages of any children or step-children:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How did you hear about New Leaf Therapy? _____

INSURANCE INFORMATION:

Insurance Company_____ Phone Number_____

Insurance ID Number_____ Group Number_____

Primary Subscriber_____ Relationship to Client_____

Primary Subscriber's Birthday_____

___ (Y/N) **Have you previously received any type of mental health services (counseling, psychiatrist)?**
If yes, provide therapist/psychiatrist name and phone number and dates you received services.

___ (Y/N) **Are you currently taking any prescription medications?** If yes, please list

___ (Y/N) **Have you ever been hospitalized at an in-patient treatment facility for psychological/emotional problems?** If yes, please give location(s), date(s), and diagnoses

___ (Y/N) **Have you ever intentionally caused harm to yourself or are you currently thinking about it?**
If yes, please describe

___ (Y/N) **Are you currently experiencing any physical health problems?** If yes, please list

How many times a week do you exercise? _____

What types of exercise do you enjoy? _____

How many alcoholic drinks do you have per week? _____

Do you smoke cigarettes_____ (Y/N) If yes, about how many per day? _____

How often do you use recreational drugs? ☐ *Daily* ☐ *Weekly* ☐ *Monthly* ☐ *Infrequently* ☐ *Never*

Are you currently in a romantic relationship?

_____ (Y/N) If yes, how long? _____

How would you rate your relationship on a scale of 1 to 10? _____

PROBLEM ANALYSIS

Briefly describe the problem(s) or concern(s) that you would like help with in counseling:

What have you already tried to do to resolve or cope with this problem?

What significant life changes or stressful events have you experienced recently?

SYMPTOM CHECKLIST: *Please check off any symptoms you have experienced in the past month.*

- ☐ Depressed Mood
- ☐ Grief
- ☐ Panic Attacks
- ☐ Anxiety/Fear
- ☐ Loss of Interest or Pleasure in Activities
- ☐ Change in Appetite
- ☐ Frequently Tired
- ☐ Insomnia
- ☐ Sleeping Too Much
- ☐ Nightmares
- ☐ Relationship Problems
- ☐ Racing Thoughts
- ☐ Easily Startled
- ☐ Flashbacks/Intrusive Memories
- ☐ Obsessions _____
- ☐ Compulsions _____
- ☐ Hallucinations/Delusions
- ☐ Phobias _____
- ☐ Difficulty Concentrating/Making Decisions
- ☐ Extreme Weight Loss/Gain
- ☐ Irritable/Easily Angered
- ☐ Feeling Hopeless/Empty
- ☐ Feeling Guilty/Ashamed
- ☐ Low Self-Esteem
- ☐ Restless
- ☐ Cutting/Hurting Yourself
- ☐ Thinking About Suicide
- ☐ Physically Violent
- ☐ Extreme Mood Shifts
- ☐ Risky Decision-Making
- ☐ Gambling
- ☐ Addictions_____
- ☐ Feeling Overwhelmed
- ☐ Frequent Crying
- ☐ Loss of _____
- ☐ Other_____
- ☐ Struggling with Past Trauma, please describe:_____

What do you hope to accomplish in therapy?

Please list the names, relations, and ages of those living with you:

Please list any significant mental health problems family members have:

Would you like anyone else involved in counseling with you? If yes, who?

What preferences do you have for days and times of appointments?

Please share any other pertinent information:

Please sign below to indicate that the information provided is true and correct:

_____ _____

Signature Date