Therapy Department
9550 Warner Ave., Suite 250-17
Fountain Valley, CA 92708 (800) 944-7004

NEW CLIENT INTAKE FORM

Demographic Information:

Name: ______________________ Date: ______________ Age : ______________

Date of Birth: ______________ Phone: ______________ Email: ______________________

Mailing Address: ____

Current Employer: ______________________ Job Title: ______________________

Status: ___ FT ___ PT ___ PRN ___ student ___ self-employed ___ unemployed

Highest Level of Education: ______________________

Military member: ___ Yes ___ No Branch: ______________________ Years Active: ______

Current Status: ___ Active ___ Reserve ___ Retired Other: ______________________

Gender Identity: ______________ Pronouns: ______________________

Name (if different than legal name): ______________________________

Emergency Contact Name: ______________________________________

Emergency Contact Phone Number: ______________ Relationship: ______________

How did you find out about Therapy Department? ______________________________

Have you had coaching/counseling before? ___ Yes ___ No

If yes, who did you see, and when: ______________________________

Have you ever been in a psychiatric hospital? ___ Yes ___ No

If yes, when? ______________________________________

Have you ever been to a substance abuse rehab program? ___ Yes ___ No

If yes, when? ______________________________________

Are there any health problems? ___ Yes ___ No

If yes, please list: ______________________________________

Do you have any form of disability? ___ Yes ___ No

If yes, explain: ______________________________________

List any medications that you are currently taking and dose:

____

____

Is there history of mental health or substance abuse issues in your family? ___ Yes ___ No

If yes, who and what type of issues: ______________________________

What issue brings you in today?

____

When did this issue begin? Please be describe events occurring at the time.

____

____

Current status: ___ Single ___ Married (since ___) ___ Living with someone (since ___)

___ Separated (since ___) ___ Divorced (since ___) ___ Widowed(since ___)

Important Previous Relationships:

Name: ______________________ Time together: _________ Married/Civil Union: ___ Yes ___ No

Why did the relationship end?

____

Name: ______________________ Time together: _________ Married/Civil Union: ___ Yes ___ No

Why did the relationship end?

____

Please check any issue you would like to discuss:

_____ Communication
_____ Anger
_____ Depression
_____ Obeseity/Weight
_____ Substance Abuse
_____ Traumatic Event
_____ Career Issues
_____ Financial
_____ Family of Origin
_____ Relationship Conflict
_____ Sex
_____ Alternative Lifestyle
_____ Polyamory
_____ BDSM/Kink
_____ Fetish
_____ Medical
_____ Swinging
_____ Infedility
_____ Transgender Identity
_____ Sexual Identity
_____ Codependency
_____ Addiction
_____ Childhood Abuse
_____ Parenting

Other: ____

Children/Stepchildren:

Name: ______________________ Age: _________ Sex: _________ Lives with you? ___ Yes ___ No
___ Child ___ Stepchild

Name: ______________________ Age: _________ Sex: _________ Lives with you? ___ Yes ___ No
___ Child ___ Stepchild

Name: ______________________ Age: _________ Sex: _________ Lives with you? ___ Yes ___ No
___ Child ___ Stepchild

Name: ______________________ Age: _________ Sex: _________ Lives with you? ___ Yes ___ No
___ Child ___ Stepchild

Is there any current or pending or divorce/custody disputes civil or criminal litigation?
___ Yes ___ No

If YES, please explain:

____

____

Name (print): ____ Date: ________________