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New Client Intake Form

This form has been designed to ask questions about your history and current symptoms in an effort to best inform your care. Please take the time to complete the form in advance of our first meeting. If you feel uncomfortable to answer any question, please feel free to leave the item blank.

Section 1: Identifying Information

Full Name: _____ Date of Birth: _____

Address: _____ Primary Phone: _____

_____ Can I leave a detailed message: Yes No

E-Mail Address: _____ Can I contact you at this address? Yes No

Sex: _____ Race: _____ Relationship Status: _____

Sexual Orientation: _____ Employment Status: _____

Are you collecting disability? Yes No Type of Disability: _____

Who referred you to Bella Vita Counseling? (Please specify name, address, and relationship to you)

_____

Insurance Company: _____ Phone: _____

Subscriber Name: _____ SSN: _____ - _____ - _____

Policy Number: _____ Group Number: _____

Are you currently involved in any legal proceedings? Yes No

If yes, please explain: _____

Section 2: Primary Complaint/Reason for Referral

Please describe your primary reason(s) for seeking therapy and/or assessment services:

_____

_____

_____

_____

Please describe how this problem(s) interferes with your daily functioning.

_____

_____

_____

_____

How did this problem(s) start? When did this problem(s) begin? Please be as specific as possible.

_____

_____

_____

_____

Section 3: Educational History

Highest Grade Completed: _____ Degree Earned: _____

Mother's Highest Education Level: _____ Father's: _____

On average, what grades did you receive in **Elementary School**: _____

In what subjects did you do particularly well: _____

In what subjects did you have difficulty: _____

On average, what grades did you receive in **Middle School**: _____

In what subjects did you do particularly well: _____

In what subjects did you have difficulty: _____

On average, what grades did you receive in **High School**: _____

In what subjects did you do particularly well: _____

In what subjects did you have difficulty: _____

On average, what grades did you receive in **College**: _____

In what subjects did you do particularly well: _____

In what subjects did you have difficulty: _____

Schools You Attended	Public/Private	Years of Attendance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SAT Scores: Verbal: _____ Math: _____ Total: _____

Did you have difficulty transitioning to kindergarten or first grade? Yes No

If yes, please explain: _____

Did you have difficulty learning to read, write, or use grammar? Yes No

If yes, please explain: _____

Did you have difficulty completing homework? Yes No

If yes, please explain: _____

What strategies have you used to try and make things easier: _____

_____

Have you ever been placed in special education, received any form of extra assistance, or had an Individualized Education Plan (IEP)? Yes No

If yes, please explain: _____

_____

Have you ever repeated a grade? Yes No

If yes, please explain: _____

_____

Have you been told by parents or teachers that you had behavioral problems? Yes No

If yes, please explain: _____

_____

Did you get into physical fights? Yes No

Have you ever been suspended or expelled? Yes No

Have you ever had a psychological assessment for a Learning Disorder, Attention-Deficit Hyperactivity Disorder (ADHD), or other psychological conditions? Yes No

By Whom: _____ When? _____

Diagnoses: _____

Note: If you have been evaluated previously, please provide a copy of the report

Section 4: Work History

Current Occupation: _____ Employer: _____

Other Recent Employment: _____

Have you ever had work difficulties (such as trouble getting along with bosses or co-workers, completing tasks thoroughly and on time, managing your time, punctuality, etc)? Yes No

If yes, please explain: _____

_____

How does your primary problem(s) relate to your work functioning: _____

_____

Section 5: Family History

Does anyone in your family have a history of emotional, behavioral, educational, substance, or medical difficulties/disorders? Yes No

Relationship to You	Type of Disorder
_____	_____
_____	_____
_____	_____

Section 6: Medical History

***Please answer the following questions to the best of your ability*.**

Were you born prematurely? Yes No If yes, how many weeks early were you born: _____

Did your mother have any difficulties during the pregnancy or birth? Yes No

If yes, please explain: _____

_____

Did your mother use alcohol, tobacco, or other drugs during pregnancy? Yes No

If yes, please explain: _____

_____

Have you ever had a serious injury or illness? Yes No

Illness/Injury	Date	Medical Treatment/Intervention
_____	_____	_____

Section 7: Current Medical Status

Please provide the contact information for your primary care physician:

Full Name: _____ Practice Name: _____

Address: _____ Office Phone: _____

_____

Have you had difficulty with vision, hearing, or other senses? Yes No

If yes, please explain: _____

Do you have any current medical concerns? Yes No

If yes, please explain: _____

_____

Are you currently on any medications? Yes No

If yes, please list: _____

Section 8: Alcohol and Drug Use

Please check any of the following that you have used:		Age of First Use:	Last Used:
_____	Alcohol	_____	_____
_____	Amphetamine	_____	_____
_____	Cocaine/Crack	_____	_____
_____	Heroin/Morphine/Opium	_____	_____
_____	Ecstasy/XTC	_____	_____
_____	Glue/Solvents/Inhalants	_____	_____
_____	LSD/Psychedelics/PCP	_____	_____
_____	Marijuana	_____	_____
_____	Tobacco	_____	_____
_____	Other (_____)	_____	_____

Please estimate your average use of the following:

	# Days per Week	Amount Each Day	Time Since Last Use
Beer	_____	_____	_____
Wine	_____	_____	_____
Hard Liquor	_____	_____	_____
Marijuana	_____	_____	_____
Tobacco	_____	_____	_____

Have you ever felt that you should cut down on your substance use? Yes No Sometimes

Has anyone ever criticized your use or suggested you cut down? Yes No

Have you felt guilty about your use? _____

Have you done things you've later regretted because of your substance use? Yes No

If yes, please explain: _____

Have you noticed a need to use more of a substance to get the desired effect? Yes No

Section 9: Psychological History

Have you ever received treatment for a psychological condition? Yes No

If yes, please explain: _____

_____

Please describe what you liked and/or benefitted from in your previous treatment:

_____

_____

Please describe what you didn't like and/or negatively affected your goals in your previous treatment:

_____

_____

Please check any of the following you have experienced:	Age of Onset	Last Occurrence
_____ **Depressed mood** (feelings of worthlessness, hopelessness, etc)	_____	_____
_____ **Stress, anxiety, or tension** (beyond a level you'd expect for the situation)	_____	_____
_____ **Distressing physical sensations** (dizziness, short of breath, increased heart rate)	_____	_____
_____ **Obsessive thoughts or images** (that you couldn't get out of your mind)	_____	_____
_____ **Repetitive behaviors or rituals** (that you could not ignore doing)	_____	_____
_____ **Distressing memories or flashbacks** (perhaps in response to a traumatic event)	_____	_____

Over the **last two weeks**, how often have you noticed the following problems:

	Not at All	**A few Days**	**Most of the Time**	**Everyday**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep or staying asleep OR sleeping too much/more than usual				

	Not at All	A few Days	Most of the Time	Everyday
Feeling tired or having little energy				
Poor appetite OR overeating				
Feeling bad about yourself (increased guilt, that you've let people down, you are a failure, etc)				
Trouble concentrating on things – (such as tasks at school/work, watching TV, following a conversation)				
Moving or speaking more slowly than usual (such that others have noticed				
Feeling more fidgety or restless (such that others have noticed)				
Thoughts that you would be better off dead or of hurting yourself				
Thoughts of hurting someone else				

If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle One)

Not at all Difficult Somewhat Difficult Very Difficult Extremely Difficult

What are you hoping to accomplish in therapy or with your psychological evaluation?

_____

_____

--- Please bring this completed form to our initial visit ---

Section 10: Addendum for Clients Seeking Evaluation for Learning Disorder (LD) or ADHD

Over the **past six months**, how frequently have you experienced the following:

	Never	Rarely	Sometimes	Often
Trouble wrapping up the final details of a project, once the challenging parts have been done				
Have difficulty getting things in order when you have to do a task that requires organization and planning				
Have problems remembering appointments or obligations				
Avoid or delay getting started on tasks that are overwhelming or intimidating to you				
Have difficulty completing one task in its entirety prior to moving onto the next task				
Fidget or squirm with your hands or feet when you have to sit down for a long time				
Feel overly active and compelled to do things, like you were driven by a motor				
Make careless mistakes when you have to work on a boring or difficult project				
Have difficulty keeping your attention when you are doing boring or repetitive work				
Have difficulty concentrating on what people say to you, even when they are speaking to you directly				
Feel restless or fidgety				
Have difficulty unwinding and relaxing when you have time to yourself				
Find yourself talking too much when you are in social situations				
Find yourself bouncing from topic to topic when in conversation with others				
Find yourself finishing the sentences of the people you're talking to, before they can finish themselves				
Have difficulty waiting your turn in situations when turn taking is required				
Interrupt others when they are busy				

It may be necessary to contact additional individuals (parents, teachers, spouse, physician) who can provide another perspective about your historical or current symptoms and level of functioning. Please provide full contact information for these persons:

Name: _____ Relationship to You: _____

Address: _____ Phone: _____

_____

Name: _____ Relationship to You: _____

Address: _____ Phone: _____

_____

Name: _____ Relationship to You: _____

Address: _____ Phone: _____

_____

By signing this, I authorize Elyse Corbett, Ph.D. to contact the individual(s) indicated above for the purposes of completing my psychological assessment.

Full Name: _____ Date: _____

Signature: _____