LORRAINE WEINER, LMFT

NEW CLIENT INTAKE/INFORMATION FORM

Welcome to my practice. Please take a few minutes and fill out the following form. This information will enable me to better meet your needs. Thank you for your time.

Name_____ Today's Date_____

(To be completed by the parent/guardian if client is younger than 18 years old)

Date of Birth_____ Age:_____ M / F

Address _____

City: _____ State:_____ Zip:_____

Email Address:_____

Do you wish to receive emails: Yes / No

Phone: H)_____W):_____ C): _____

May I call you …at home? Yes / No ….at work? Yes / No

Emergency Contact_____ Phone _____

Current relationship Status: Single Married- Date:_____

Co-habitating –Date:_____ Separated- Date_____

Divorced- Date:_____ Widowed- Date:_____

Prior Marriages: Please list all prior marriages, including the year of marriage and/or divorce:_____

_____

Please list all of your children:
Name _____age_____ In Home ____Y____N

Name _____age _____In Home ____Y ____N

Name _____age _____In Home ____Y ____N

Name _____age _____In Home ____Y ____N

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Employer/School:_____

Occupation:_____

Referred by:_____

Person to be contacted in case of an emergency:

Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____

Presenting Problem(s):

Please describe your reasons for seeking counseling at this time (include date/month the problem started):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Trauma History:

Physical Abuse Yes No
Emotional Abuse Yes No
Sexual Abuse Yes No
Victim of Violent Crime Yes No
Domestic Violence Yes No
other incident Yes No

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If Yes to Trauma History, briefly describe:_____

_____

Substance Use:
Is there family or personal history of substance issues? If yes, please describe:
_____
_____
_____

Substances: (Please specify use any of the following substances)

🕷 Coffee/Caffeine _____Cups/Day 🕷 Alcohol_____drinks per week
🕷 Cigarettes per day_____For how long?_____
🕷 Illegal Drugs (If yes, please list the type, amount and how often)_____
_____
Most recent use of any illegal drugs_____
How many years of use_____

Has anyone ever told you that your substance use is a problem? 🕷 Yes 🕷 No

Which substances?_____

Have you ever received any kind of substance abuse treatment 🕷 Yes 🕷 No
If yes, please describe and give dates (i.e., 12 Steps, IOP, Detox)_____
_____

Psychiatric History
Is there any **family history** of psychiatric illness or treatment? 🕷 Yes 🕷 No
If yes, please explain:_____
_____

_____

_____

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Psychiatric History (Cont'd):

Have you ever been to see a psychiatrist or therapist before today? 🕷Yes No

If yes, when was the treatment: _____

_____

_____

For how long and if you stopped, why?_____

_____

Name of provider(s) _____

Were any ***medications*** ever prescribed to you by a psychiatrist/other provider (PCP, OB-GYN, Nurse Practitioner) for any psychiatric illness/symptoms?
🕷Yes 🕷No

If yes:
What ***previous*** medications were you prescribed? (no longer taking):

_____

_____

Your Response: _____

_____

Why did you stop taking these medication(s)?_____

_____

Current Prescription Medications including dosage and frequency:

1) _____ 2)_____
3) _____ 4)_____
5)_____ ____ 6)_____

Over the Counter Medications/Supplements/Herbs:
Medication: Dose: How Often:

_____

_____

_____

_____

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Do you have any allergies to medications? Yes/No
If yes, please list medications:_____
_____

Have you ever been hospitalized in a psychiatric facility? Yes No

Hospital(s):_____
Dates:_____

Reason for Admission(s):_____
Length of stay:_____

***Medical History*:**
Please list any medical conditions and/or illnesses for which you are currently being treated or have been treated for in the past and give dates of treatment:

_____
_____
_____
_____
When was your last physical exam and by whom?_____
_____
If you have ever had surgery, please list below:
_____ Date:_____
_____ Date:_____
_____ Date:_____
Please add any information that you would like me to know that is relevant to your treatment:

_____
_____
_____
_____
_____

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PROBLEM CHECKLIST

Please list which of the problems listed below are bothering you at this time.

0 = NONE 1 = MILD 2 = MODERATE 3 = SERIOUS 4 = SEVERE

0 1 2 3 4 Previous episodes of depression
0 1 2 3 4 Previous episodes of elation
0 1 2 3 4 Feel Sad
0 1 2 3 4 Cry easily
0 1 2 3 4 Feel hopeless
0 1 2 3 4 Feel guilty
0 1 2 3 4 Feel irritable
0 1 2 3 4 Feel anxious
0 1 2 3 4 Feel worthless
0 1 2 3 4 Think about suicide
0 1 2 3 4 Past suicide attempts
0 1 2 3 4 Not able to have fun
0 1 2 3 4 Loss of interest in usual pleasures
0 1 2 3 4 Unmotivated to complete tasks

0 1 2 3 4 Loss of interest in sex
0 1 2 3 4 Sexual performance problems
0 1 2 3 4 Confusion
0 1 2 3 4 Loss of energy
0 1 2 3 4 Fatigue
0 1 2 3 4 Body feels slowed down
0 1 2 3 4 Thoughts feel slowed down
0 1 2 3 4 Body feels sped up
0 1 2 3 4 Racing thoughts
0 1 2 3 4 Hear voices
0 1 2 3 4 Suspiciousness/Paranoid thoughts
0 1 2 3 4 See things that aren't there
0 1 2 3 4 Strange thoughts
0 1 2 3 4 Fits of rage
0 1 2 3 4 Think about hurting someone
0 1 2 3 4 Poor self-control
0 1 2 3 4 Work problems
0 1 2 3 4 Relationship problems
0 1 2 3 4 Problems with money
0 1 2 3 4 Legal problems

0 1 2 3 4 Nightmares
0 1 2 3 4 Problems concentrating
0 1 2 3 4 Memory problems
0 1 2 3 4 Indecisiveness
0 1 2 3 4 Withdrawal from others
0 1 2 3 4 Episodes of panic
0 1 2 3 4 Fear of being in public
0 1 2 3 4 Phobias
0 1 2 3 4 Fear of weight gain
0 1 2 3 4 Trouble making friends
0 1 2 3 4 Loneliness
0 1 2 3 4 Unwanted, distressing thoughts
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Troublesome dreams, nightmares, feelings about traumatic events
0 1 2 3 4 Constant worry
0 1 2 3 4 Anxious, on edge
0 1 2 3 4 Bowel disturbances
0 1 2 3 4 Ongoing laxative use
0 1 2 3 4 Chronic pain
0 1 2 3 4 Worry over health
0 1 2 3 4 Medical problems
0 1 2 3 4 Skipped menstrual periods
0 1 2 3 4 Unhappy with weight
0 1 2 3 4 Recent weight gain or loss
0 1 2 3 4 No appetite
0 1 2 3 4 Binge eating
0 1 2 3 4 Intentional vomiting
0 1 2 3 4 Trouble falling asleep
0 1 2 3 4 Sleeping too much
0 1 2 3 4 Trouble staying asleep
0 1 2 3 4 Waking up too early
0 1 2 3 4 Problems with food
0 1 2 3 4 Problems at home

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