New Client Intake
Lori Brady Counseling, LLC

Identification and Contact Information Today's Date: ____-_____-____

Name: ________________________________ Email address: ___________________________

Gender: F M Date of Birth: ____ - _____ - _____ Age: _______

Address ___________________________________ City _____________ Zip ___________

Home Phone ( )___________________________ Work ( ) ______________________

Cell / other ( ) _____________________Preferred number for contact ________________

May I identify myself when I call this number, should someone beside yourself answer?_____

Emergency Contact: Name ____________________________ *Relationship* ______________

Phone _____________________

Referral: How where you referred?______________________

Presenting Concern: Please describe the main difficulty or reason you are coming for counseling and include why now?:

____

____

____

____

____

Please describe your goals for counseling: ____

____

____

How will we know when you have achieved your stated goals?

____

____

____

Relationships

If currently in a relationship please briefly describe the nature of the relationship: __________

____

Partner's age: _____ Has your partner previously been married? ____ How many times? ___

How long since partner's last marriage? __________ Does your partner have children from a previous relationship? _____ Do you have similar parenting styles? ______

Describe your relationship with the children________________________________

Names / Ages of children: ____

Education, degrees of partner? ___________________________ Occupation?_______________________

Is partner currently employed? ________ How long? ______________

With Whom are you currently living? *(Please list name, relationship, age, how you get along and if there are any issues of concern related to alcohol/ drug use, mental or physical illness):*____
____
____
____
____

Do you have any children who **do not** live with you or are *not* in your custody? ______
If so, please list their names, ages, circumstances:

____

____

In a few words, how would you describe your relationship with mother or maternal figure that raised you (if applicable):____

Please describe your relationship with your father or paternal figure that raised you (if applicable):____

How was it to grow up in your family? ____

Are there any traumas/ traumatic events that you experienced while growing up (physical abuse, sexual abuse, neglect, divorce, frequent moving) that you would like to share?
____
____

Educational / Occupational / Military

Highest grade / degree completed: ____
Current student? _____ Where? __________________ What are you studying? __________
Current Occupation: ________________________________ How Long? ______________
Employer: _______________________________________ How Long? ______________
Address: ____
If not employed, how long has it been since you worked? ____________________________
What kind of job did you have? ____
What caused you to stop working? ____
What other types of work have you done in the past? _________________________________

Have you ever been or are you now in the military? _____

Which Branch? __________________________

What was your specialty? ___________________

What was your rank at discharge? _____________ Honorable Discharge? ______

Have you sought any services from the VA? ______________________________________

Are you experiencing any kind of trauma/ difficulties related to your service? _____

Health / Medical

From whom or where do your receive medical care? ________________________________

Address: ____ Phone: ________________

When was your last medical exam? ____

Current health concerns: ____

Are you currently receiving treatment for these concerns? ____________________________

Past health concerns and accidents: ____

____

List current medications & dosage /vitamins/supplements that you take:

____

Women only:
How many pregnancies have you had? ___________ Are you pregnant now? ______________
Number of miscarriages ______ Number of terminations______
Are you currently experiencing any fertility issues? __________________________________

Are you currently concerned about your eating habits? _____

If so, briefly explain:____

Are you currently concerned about your sleep habits? _____
If so, briefly explain:____

Do you currently exercise? ______ If yes, how often? ______________________________
What of exercise? ____

Spiritual/Religious Beliefs/Practices:

Is Religion or spirituality an important part of your life (please list practice if comfortable)?
____
Are you affiliated with any particular religion or place of worship? ________________________
What gets you through difficult periods in your life? ______________________________________
____
What brings you hope and joy? ____
____

Previous Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? _____ If yes, please indicate:

When?	From Whom?	For What?	With What Results?

Are you thinking about suicide now? _______
Is there a family history of completed or attempted suicide?______If yes, please list relationship and approximately when____
Have you made any final plans? _______________________Do you own a weapon? _________
Have you ever **attempted** suicide & how many times? ___________
If you answered yes, please indicate when, how and the outcome/ treatment received:____
____

Do you now or have you ever engaged in self-harm (e.g. cutting, burning, or hurting yourself in any way) or other potentially damaging or impulsive behaviors (e.g. unsafe sex practices, gambling, impulsive spending)? _______ If yes, please describe when you started, frequency, what you did, the last time you engaged in the behavior(s) and anything else you think is important for me to know.
____
____
____
____

Chemical Use

Do you feel like you are using drugs or alcohol more than you would like?_____________
Please described your use and concerns_______________________________________

Legal

Please list and describe any arrests, incarcerations or legal issues or problems (include custody issues):

____

____

Circle any problem that pertains to you at this time:

Coping skills	Stress	Self Harm
Memory	Weight	Current employment
Anxiety	Energy	Overeating
Drug/alcohol use	Loneliness	Marriage/ relationship
Anger	Education	Sexual problems
Sleep	Undereating	Fertility issues
Friends/supports	Concentration	Nightmares
Future	Motivation	Divorce/ separation
Negative thoughts	Parenting	Health problems
Finances	My appearance	Suicidal thoughts
Abuse	Children	Career choices
Depression	Headaches	Legal matters
Self-esteem	Sexual Orientation	Grief/ Loss

Anything not listed____

Circle everything that has happened to you in the past 3 years:

Death of a spouse/partner	Marriage Problems	Changes in marital status
Death of another family member	Family problems (children, in-laws)	Loss of job
Major illness or injury–yourself	Financial problems	Move
Major illness or injury–family member	Legal problems	Other: _____________

Please describe your strengths: ____

Please describe your limitations (what holds you back from accomplishing what you want in life?):

____

Who/What are your supports: ____

____

Please rate your level of motivation for change (0 to 10 with 10 the highest) _______________

Please list any additional information that you believe may be helpful or that you want me to know:

____

Lori Brady, LPCC