Arden Shores
COUNSELING

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Intake form for new patients

Main Concern/reason for coming:

Medical History

Please list all previous mental health services and hospitalizations:

Please list current and past medical conditions/surgeries:

General medical health:

List of current medications with strength and frequency:

How often do you exercise, and for how long in a typical week?

(Optional) Height _____ft_____ inches Weight _____lbs.

Any concerns about current diet, eating habits or life style?

Significant family health history:

Any family history of mental health conditions?

Any family history of alcohol or drug use/chemical dependency?

Are you aware of any complications during pregnancy or labor (of the client)?:

Any developmental/health problems or accidents in childhood:

Do you currently of have you ever:

Smoke/vape or use any nicotine or tobacco? ◯Yes ◯No Freq:

Alcohol use: ◯Yes ◯No Freq:

Marijuana/cannabis: ◯Yes ◯No Freq:

Other drugs: ◯Yes ◯No Type: Freq:

Prescriptions (that are not prescribed to you): ◯Yes ◯No Name: Freq:

Social History

Current living situation and other people in the home:

Please describe your social supports and import relationships, including friends or family:

Does the client provide for their own basic needs? ◯**YES** ◯**NO**

If no, who does: ◯**Parents** ◯**Guardian** ◯**Spouse** ◯**Other:**

Is the client: ◯ **A Minor** ◯**Vulnerable Adult**

Level of education:

Current grade:

High school graduate or GED

College:

18 and under- Do you have a current IEP or 504 plan? ◯**YES** ◯ **NO** ◯**N/A**

If yes, what service do you receive:

Employment:

Strengths and personal resources:

Any religious or spiritual beliefs, (or concerns)?

Would you like religious or spirituality included or addressed in therapy: ◯**YES**◯**NO**

Cultural and person identity (including race, ethnicity, sexual/ gender identify, SES, etc):

Any personal or cultural beliefs that would impact therapy/ treatment?

Have you experienced any disasters, misfortunes or major life stressors during your life?

Have you experienced frequent moves, changes in school or other stressful transitions?

Experienced any type of abuse: _____emotional _____verbal____ physical _____Sexual

Details (optional):

Do you feel safe at home? ◯Yes ◯No

Any other safety concerns?

*Symptoms and goals will be discussed at the first appointment.