SCW Psychological, Inc.

New Client Intake Form

Please provide the following information and answer the questions below. Please note that information provided herein is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____

Birth Date: _____ /_____ /_____ Age: _____

Social Security No.: _____ - _____ - _____ Gender: □ Male □ Female

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Telephone: (_____) _____ - _____ May I leave messages? □ Yes □ No

Mobile Telephone: (_____) _____ - _____ May I leave messages? □ Yes □ No
May I send text messages? □ Yes □No

E-mail: _____ May I email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Marital Status

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Insurance Information

Ins. Carrier: _____ Name of Primary Policy Holder: _____

Member ID: _____ Group No.: _____

Ins. Billing Address: _____ Ins. Telephone No.: _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes

If yes, please list all previous therapists/practitioners: _____

Are you currently taking any prescription medication?

□ No □ Yes

If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ No □ Yes

If yes, please list and provide dates: _____

_____

Have you ever been hospitalized?

□ No □ Yes

If yes, please list dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. **How would you rate your current physical health? (Please circle one)**

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific health problems you are currently experiencing:

   _____

2. **How would you rate your current sleeping habits? (Please circle one)**

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. **How many times per week do you generally exercise?** _____

   Types of exercise in which you participate: _____

4. **Please list any difficulties you experience with your appetite or eating patterns.**

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week?

□ No □ Yes

9. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?

□ No □ Yes

If yes, for how long? _____

11. Have you recently experienced any significant life changes or stressful events (if so, explain):

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In this section, please identify if you have a family history of any of the following. If yes, please indicate the family member's relationship to you (i.e. father, grandmother, uncle, etc.) in the space provided.

	Please Circle One	*List Family Member(s)*
Alcohol/Substance Abuse	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Domestic Violence	Yes / No	_____
Eating Disorders	Yes / No	_____
Obesity	Yes / No	_____
Obsessive Compulsive Behavior	Yes / No	_____
Schizophrenia	Yes / No	_____
Suicide Attempts	Yes / No	_____

ADDITIONAL INFORMATION

1. Are you currently employed?

□ No □ Yes

If yes, what is your current employment situation: _____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious?

□ No □ Yes

If yes, describe your faith or belief: _____

_____

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____