Orchard Human Services, Inc.

New Client Intake Form

Name:_____ Date: _____

Nickname or Preferred Name: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

*Email: _____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): _____ OR - If not referred, then:

How did you hear about us? _____

Reason for requesting services with this facility/practitioner? _____

_____

Please describe any past counseling or mental health services that you have received in the past:

If you had previous services, what did you like? What was effective or helpful?

If you had previous services, what did dislike? What was not effective or helpful?

Please use other side for additional information.

Medical History

Who is your primary care provider?

Doctor's Name: _____Phone Number:_____

Address: _____

Date of your last medical examination: _____

Do we have permission to contact your doctor to promote continuity of care? ___ Yes ___ No

Did your mother smoke tobacco or use any alcohol, drugs or medications during her pregnancy with you? If so, please list which ones:

Did your mother have any problems during the pregnancy or at delivery? If so, please describe them:

Have you experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Please list any current medical problems or physical handicaps:

Please last any previous surgeries, serious accidents or injuries, medical diagnoses, or medical problems:

Please list any medications you take on a regular basis:

Please indicate if you use any of the following:

Alcohol	YES NO
Recreational Drugs	YES NO
Tobacco Products	YES NO
Other Mind-Altering Substances	YES NO

Mental Health History

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

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

_____

General 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? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics 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 If yes, how often? _____

How much alcohol do you consume? _____

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? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship and why?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____

_____

Family Mental Health History

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

Please Circle Situation and List the Involved Family Member:

Alcohol/Substance Abuse yes / no _____ Anxiety yes / no _____

Depression yes / no _____ Domestic Violence yes / no _____

Intimate Partner Violence yes / no _____ Self-Harm yes / no _____

Eating Disorders yes / no _____ Obsessive Compulsive Behavior yes / no _____

Obesity yes / no _____ Schizophrenia yes / no _____

Suicide Attempts yes / no _____ Mental Health Diagnosis yes / no _____

Sexual Abuse yes / no _____ Physical Abuse yes / no _____

Other Concerning Situation 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? _____

_____

_____

Other History:

Do you ever think about wanting to hurt yourself or seriously hurt someone else? Circle YES NO

Have you ever purposely hurt yourself or another person? Circle YES NO

If yes to either question, please describe the situation:

Do you have a trauma history [have you ever experienced trauma, abuse, neglect, or a major disaster/loss/life event]? Circle: YES NO

If yes, please explain:

Have you ever experienced any serious emotional losses (such as a death of or physical separation from an important person in your life … such as a spouse, life partner, child, parent, caretaker, etc.)? Circle: YES NO

If yes, please explain:

What are some of the things that are currently stressful to you – and if it applies to you, that are stressful to your family or close circle of friends/business associates/life partner/etc.:

END OF REGULAR INTAKE FORM – ONLY PROCEED IF THE FOLLOWING CONDITIONS APPLY TO YOU

ADDITIONAL INTAKE FORM – Only proceed if one of the following applies to you:

☐ **You are an adult or young adults who is still in school**

- OR-

☐ **You are an adult who is dealing with issues that may be impacted by learning or memory problems, childhood events or relationships, developmental issues, bullying that date back to childhood or adolescence, and school experiences.**

Behavioral Excesses:
As a child, what did you do too often, too much, or at the wrong times that got you in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
As a child or adolescent, what did you fail to do as often as you should have, as much as you should have, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What did you do as a child that you liked? What did you do that other people like?

Others Concerns:
Do you have any other concerns about your experiences during childhood or adolescence that you would like to share or discuss, or that still bother you:

Treatment Goals:
From your preceding list of your behavior and personal concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please use other side for additional information.

When you were a child, who were the other household members?

Names	**Ages**	**Relationship to child**

Who were significant others who did NOT live with you when you were a child?

Names	**Ages**	**Relationship to child**

Education and Professional History:

What schools did you attend? What degrees or credentials have you earned? Please list:

_____

_____

_____

_____

What things did your teachers or instructors say about you? How would your teachers/instructors describe you?

Have you ever repeated a grade? If so which one(s)?

Have you ever received special education services?

As a child, did you experience any of the following problems at school?

Fighting Lack of friends Drug/Alcohol Detention

Suspension Learning Disabilities Poor attendance Poor grades

Gang influence Incomplete homework Behavior problems

Please use other side for additional information.