Therapy Department
135 Jenkins St., Suite 105B, Box 305
St. Augustine, FL 32086

NEW CLIENT INTAKE FORM

Demographic Information:

Name: _____ Date: _____ Age : _____
Date of Birth: _____ Phone: _____ Email: _____
Mailing Address: _____
Current Employer: _____ Job Title: _____
Status: ☐ FT ☐ PT ☐ PRN ☐ student ☐ self-employed ☐ unemployed
Highest Level of Education: _____
Military member: ☐ Yes ☐ No Branch: _____ Years Active: _____
Current Status: ☐ Active ☐ Reserve ☐ Retired Other: _____
Gender Identity: _____ Pronouns: _____
Name (if different than legal name): _____
Emergency Contact Name: _____
Emergency Contact Phone Number: _____ Relationship: _____

How did you find out about Therapy Department? _____
Have you had coaching/counseling before? ☐ Yes ☐ No
If yes, who did you see, and when: _____
Have you ever been in a psychiatric hospital? ☐ Yes ☐ No
If yes, when? _____
Have you ever been to a substance abuse rehab program? ☐ Yes ☐ No
If yes, when? _____
Are there any health problems? ☐ Yes ☐ No
If yes, please list: _____
Do you have any form of disability? ☐ Yes ☐ No
If yes, explain: _____
List any medications that you are currently taking and dose:

_____

_____

Is there history of mental health or substance abuse issues in your family? ☐ Yes ☐ No
If yes, who and what type of issues: _____
What issue brings you in today?

_____

When did this issue begin? Please be describe events occurring at the time.

_____

_____

Current status: ☐ Single ☐ Married (since ___) ☐ Living with someone (since ___)
☐ Separated (since ___) ☐ Divorced (since ___) ☐ Widowed(since ___)

Important Previous Relationships:

Name: _____ Time together: _____ Married/Civil Union: ☐ Yes ☐ No

Why did the relationship end?

_____

Name: _____ Time together: _____ Married/Civil Union: ☐ Yes ☐ No

Why did the relationship end?

_____

Please check any issue you would like to discuss:

☐ Communication	☐ Family of Origin	☐ Swinging
☐ Anger	☐ Relationship Conflict	☐ Infedility
☐ Depression	☐ Sex	☐ Transgender Identity
☐ Obeseity/Weight	☐ Alternative Lifestyle	☐ Sexual Identity
☐ Substance Abuse	☐ Polyamory	☐ Codependency
☐ Traumatic Event	☐ BDSM/Kink	☐ Addiction
☐ Career Issues	☐ Fetish	☐ Childhood Abuse
☐ Financial	☐ Medical	☐ Parenting

Other: _____

Children/Stepchildren:

Name: _____ Age: _____ Sex: _____ Lives with you? ☐ Yes ☐ No
☐ Child ☐ Stepchild

Name: _____ Age: _____ Sex: _____ Lives with you? ☐ Yes ☐ No
☐ Child ☐ Stepchild

Name: _____ Age: _____ Sex: _____ Lives with you? ☐ Yes ☐ No
☐ Child ☐ Stepchild

Name: _____ Age: _____ Sex: _____ Lives with you? ☐ Yes ☐ No
☐ Child ☐ Stepchild

Is there any current or pending or divorce/custody disputes civil or criminal litigation?
☐ Yes ☐ No

If YES, please explain:

_____

_____

Name (print): _____ Date: _____