New Beginnings Therapy Services, Inc.

INDIVIDUAL CONCERNS INTAKE

Name: _____ Client File #: _____

Check any of the following words which best describe you *at this time*.

___Active	___Impatient	___Calm	___Outgoing	___Lonely
___Ambitious	___Impulsive	___Serious	___Likable	___Shy
___Angry	___Moody	___Easy-going	___Leader	___Sensitive
___Persistent	___Often Blue	___Self-Conscious	___Follower	___Optimistic
___Nervous	___Excitable	___Self-Confident	___Imaginative	___Pessimistic

Check any of the following struggles or difficulties that you are experiencing *at this time*.

___Abuse (present)	___Depression	___Guilt	___Envy
___Abuse (past)	___Parenting	___Chronic Pain	___Grief
___Anxiety	___Marital Intimacy	___Homosexuality	___Work Issues
___Apathy	___Moodiness	___Addiction	___Purpose
___Bitterness	___Memory Loss	___Suicidal Thinking	___Step-Family Issues
___Lifestyle Change	___Financial Management	___Panic Attacks	___Trust
___Pornography	___Peer Issues	___Bad Memories	___People Pleasing
___Communication	___Obsessions / Compulsions	___Self-Injury	___Anger
___Conflict Resolution	___Time Management	___Co-Dependency	___In-Laws
___Procrastination	___Eating / Food Issues	___Fear	___Other _____

List any medical problems you have:

_____

_____

_____

_____

List medications you are taking:	Reason for taking:
_____	_____
_____	_____
_____	_____
_____	_____

List any other counseling you are receiving or have received.

Name or Agency:	Reason for counseling:
_____	_____
_____	_____
_____	_____

Have you ever been physically, sexually, or emotionally abused? **No** **Yes** If yes, briefly describe: _____

_____

_____

_____

Have you ever been hospitalized for mental or nervous problems? **No** **Yes** If yes, when and where? _____

_____

Have you ever attempted suicide? **No** **Yes** If yes, how, when and where? _____

_____

Are you thinking of harming yourself now? **No** **Yes**

How often do you drink alcohol? _____

Have you ever been arrested for driving under the influence (DUI)? **No** **Yes** If yes, how many times? _____

Do you use drugs? **No** **Yes** If yes, what drugs and how often? _____

_____

Are you concerned about drug or alcohol usage by members of your family? **No** **Yes** If yes, who? _____

Have you ever been arrested? **No** **Yes** If yes, how many times and for what? _____

_____

Are you currently involved or do you expect to be involved in any court related matters? **No** **Yes**

If yes, please describe: _____

Briefly, what is going on in your life that brings you to therapy? _____

_____

_____

_____

What important things about your life would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

_____

_____

_____

What initial goals do you want to work on during therapy? _____

_____

_____

_____

Signature: _____ Date: _____