evolvepsychologycenter.com

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New Client Intake Form

Today's Date ___________

First Name: _________________________ Last name: ________________________________

Birth Date: ______ /______ /______ Age: ________

Address: ____

City________________________________ State_____ Zip____________

Cell Phone: _________________________ May we leave a message? □ Yes □ No

Other Phone: _________________________ May we leave a message? □ Yes □ No

Email: ____ May we email you? □ Yes □ No

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

Preferred method of contact (ok to select more than one): Cell □ Home □ Text □ Email □

Emergency Contact Name: ____

Relationship:___________________________ Phone number:_________________________

Patient Occupation:____

Place of Employment: ____

Gender Female □ Male □ Transgender □ Other:

Sexual Orientation
Bisexual □ Heterosexual □ Lesbian/Gay Queer □ Questioning □ Other:

Relationship Status
Single□ Partnered □ Married □ Separated □ Divorced □ Widowed □

Referred by
Friend/Family □ Medical Provider □ Website□ Psychology Today □ Other:

Denver/Boulder, CO 202.669.9070 melanie@evolvepsychologycenter.com

Briefly describe what brings you to Evolve Psychology Center:

(B2) Approximately how long has this concern been bothering you?

Days Weeks Months Several months 1 Year Several years Most of my life

Please CIRCLE ITEMS THAT APPLY.

Addictions	Impulsive behavior	Obsessive thoughts
ADHD/learning problems	Family problems	Panic Attacks
Adjustment to new situations	Feeling doomed or helpless	Paranoia
Alcohol or drug concerns	Financial concerns	Phobias / fears
Anger management	Identity/sense of self	Physical abuse or assault
Anxiety, fear, nervousness	Impulse control	Procrastination
Compulsive Behavior	Internet/videogame concerns	Relationship concerns
Concentration difficulties	Intimate relationship concerns	School/Job/Career Concerns
Concern with another's wellbeing	Interpersonal concerns	Sexual abuse or sexual assault
m) Cultural/multicultural concerns	Legal concerns	Sexuality concerns
n) Cutting or self injury	Loneliness	Sleep difficulties
0) Depression, sadness	Loss, grief, death	Spiritual or religious concerns
p) Discrimination	Self-esteem	Stress or tension
q) Eating concerns/body image	Medical or health concerns	Thinking about suicide
r) Emotional or psychological abuse	Mood swings	Thoughts racing through your mind
		Trouble making decisions or getting things done

Other presenting concern (specify):

Please indicate which of the above concerns are most important to you and your current level of distress (1 = minimal, 5 = unbearable)

Most Important: ___________ 1 2 3 4 5

Second Most Important: _________ 1 2 3 4 5

Third Most Important: _________ 1 2 3 4 5

How much do your concerns interfere with your:
(Low Interference = 1, Severe Interference = 5)

Work/School Performance	1	2	3	4	5
Relationships	1	2	3	4	5
Daily Routines / Self-Care	1	2	3	4	5
Emotional Wellbeing	1	2	3	4	5

MENTAL HEALTH HISTORY

Have you received counseling or psychotherapy in the past: Yes No

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

Yes (specify below) No

If YES, please provide the provider's name and phone number:

Have you been prescribed psychiatric medication in the PAST or CURRENTLY?

Yes (specify below) No

Are/Were the medications helpful?
Yes No

Please list past and present psychiatric medications, dosage, and when taken:

Have you been hospitalized for psychiatric reasons? Yes (specify below) No

If YES, please specify reason for past hospitalization: (check all that apply):

Psychological problems Suicide ideation/attempt Dangerousness to others Drug/alcohol
Other (specify below)

Please specify when and where you were hospitalized:

Have you ever had thoughts of harming yourself? Yes No

Have you ever tried to harm yourself or take your life? Yes No

Have you done anything dangerous where you could have died? Yes No

Have you wished (or currently wish) you were dead or wished you could go to sleep and not wake up? Yes No

Do you regularly use alcohol? Yes (specify below) No

In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?

Never Rarely Monthly Weekly Daily or Almost Daily

How often do you engage in recreational drug use?

Never Rarely Monthly Weekly Daily or Almost Daily

Have you ever received treatment for alcohol or drug use? Yes (specify below) No

If YES, indicate when and where

What is your typical DAILY CAFFEINE intake?

Never or infrequently 1-2 cups/servings 3-5 cups/servings 5+ cups/servings

What is your typical DAILY NICOTINE intake?

Never or infrequently Less than 5 cigarettes 5-20 cigarettes More than 20 cigarettes

When was your last physical exam?

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Excellent

Have you had any serious accidents, injuries, or illnesses?? Yes (specify below) No

Are you presently taking any medications? (e.g., prescribed medications, over-the-counter drugs, alternative remedies, etc.)

Yes No If YES, please list:

Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

Are you having any problem with your sleep habits?

No problems Sleeping too much Sleeping too little Poor quality of sleep Disturbing dreams
Other (please describe)

How many times per week do you exercise? One or less Two to Four Five or more

What kind of exercise do you do?

Are you having difficulty with appetite or eating habits?

No difficulty Eating less Eating more Binging Restricting Significant weight change
Other (specify below)

Do you have any problems or worries about sexual functioning? (check all that apply)

No concerns Lack of desire Performance problem Sexual impulsiveness
Difficulty maintaining arousal Worried about sexually transmitted disease
Other (specify below) If OTHER, please describe:

Besides family members, approximately how many people can you really count on right now for friendship and emotional support?

Approximately how many significant intimate relationships (lasting 6 months or more) have you been involved in the last couple of years?

Are you in a significant intimate relationship now?

Please list the members of your current family, including ages and occupations

Were you and both your parents born in the USA? Yes No (specify below)

If NO, please describe who was foreign-born, where, and what was the approximate age of immigration:

In general, how happy or adjusted were you growing up?

Not at all Unsatisfactory Average Substantially Completely

Does your family speak a language other than English at home? No Very little Sometimes Very Much

If YES, what language(s):

What is your ethnic identity?

How much do you identify with your ethnic heritage? Not at all A little Somewhat Strongly

How much conflict in values do you currently experience with your parents?

Very little or none Some Moderate Strong

Religious preference: ____________________ **Are you currently active in your religion**? Yes No

How much is your immediate family a source of emotional support for you?

Not at all A little Somewhat Substantial
Very strong

Have you personally experienced LEGAL PROBLEMS? Yes No

If YES, please describe:

Did you experience LEARNING PROBLEMS in elementary or high school?

None A little Some Substantial A lot

Do you have children? Yes No If YES, please list age and gender of children:

Please check any past, present, or impending problems in your family. Please specify the problem, family member(s), and time of occurrence:

a) DIVORCE/MARITAL PROBLEMS

b) SERIOUS PHYSICAL ILLNESS, DISABILITY, OR DEATH

c) ALCOHOL/SUBSTANCE ABUSE PROBLEMS

d) PSYCHIATRIC ILLNESS/EMOTIONAL PROBLEMS

e) FINANCIAL PROBLEMS/UNEMPLOYMENT

f) LEGAL PROBLEMS

g) OTHER

We will discuss all of the notable information from above, but is there anything else you'd like me to know about you?