Santel & Kerr LLC
counseling services

New Client Intake Form (Adult)

Name: ____Age: ______________________________ Birth date: ___ ____Gender/Gender Identity :____________

Client SSN: ____________________________________

Cell number: __________________________________Is it ok to leave a message?__________

Address: ____ City: _ _________________________________State: ______________Zip code: __________________

Email: ____

Is it ok to email?___________________

Emergency Contact:

Name: _______________________________________ Phone Number: ____________________

Are you currently in counseling? (please check one): _____ Yes ______ No

Counseling History: Please include all psychotherapists, psychiatrists, psychologists, occupational therapists, equine therapists, neurofeedback, or any other types of therapy or treatment you have pursued.

Dates	Therapist	Why	How Helpful (0-10)

Name of primary physician and phone number:____

List any health issues, medical diagnoses, or disabling conditions:

What medications are you currently taking?

Medication	Dose	For what

Presenting Problems:

Please do your best to express to me *what it feels like to be you* on any given day?:

Can you identify any event or experience that preceded these challenges?

When did you first notice these symptoms (approximately?)

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Client Demographics

Full legal name: ____

Ethnic identification: ____________________

Occupation: ___________________ Employer:____________________

Work Phone Number:_______________

Are you currently serving, or have you ever served, in the military? ______ Yes ______ No

If yes, please describe: ____

Please describe any current or past relationship status: ________________________

____

Family/Home Information- Please list everyone who resides in your home full or part time

Name	Age	Relationship to You	Full or Part Time Home Member	Gender

Does anyone else in your family:

- Have a history of mental illness? _______ YES _____________ NO ___________ UKNOWN

If yes, explain:

- Have a known or suspected history of trauma? _______ YES _____________ NO _________ UNKNOWN

If yes, explain:

Development & Early History: Please answer to the best of your ability. If unknown to you, please leave blank.

	YES	NO	UNKNOWN
Was your mother's pregnancy planned?			
Were there any prenatal problems?			
Did the birth mother experience any unusual stress during pregnancy?			
Were you exposed to any drugs or alcohol in utero?			
Were there any problems with delivery?			
Did your birth mother suffer post-partum depression or anxiety?			
Was there any unusual stress in the year after birth?			
As an infant, did you have feeding problems?			
As an infant, did you sleep well?			
Were you separate from your birth mother after birth, even briefly?			

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Did you meet developmental milestones?			
As a child, did you struggle with bedwetting/soiling (beyond developmentally appropriate?)			
As a child, did you experience multiple ear infections?			
As a child, were you ever hospitalized?			
As a child, did you ever have a head injury?			

Would you (or others) describe your childhood in any of these ways during your first years?

	YES	NO	UNKNOWN
Did not enjoy cuddling			
Difficult to comfort			
Restless			
Head Banging			
Reflux			
Not calmed by being held			
Colic			
Excessive irritability			
Constantly into everything			
Listless/Unresponsive			
Overactive			
Adapted easily to change			
Intense feelings			

Has anyone ever told you that they worried you had a problem with alcohol and/or drugs? Please explain:

Are there parts of your birth history or early childhood years that are unknown or confusing to you?

What changes do you want to see as a result of treatment?

Concurrent Stressors or Symptoms:

___Depressed mood
___Worry/rumination
___Feelings of shame
___Feelings of guilt
___Fatigue/Low energy
___Poor concentration
___Irritability/Anger
___Substance Use issues
___Anxiety
___Hopelessness
___Emptiness
___Social Isolation
___Worthlessness
___Loss of pleasure in hobbies
___Appetite gain/loss
___Weight gain
___Weight loss
___Intense crying
___Recurring thoughts/images
___Feelings of panic
___Difficulty controlling emotions
___Loneliness
___Memory problems
___Disorganized thoughts
___Thoughts of suicide
___Attachment issues

___Disordered eating/food issues
___Migraines
___Scoliosis
___Financial problems
___Sexual trauma/assault
___Employment issues
___Lack of emotional support
___Infidelity/betrayal
___Childhood trauma
___Hypersensitivity
___Dissociation or "Zoning out"
___Childhood physical abuse
___Childhood sexual abuse
___Emotional/mental abuse
___Seeing or hearing unusual things
___Sexual dysfunction/challenges
___Fainting
___Compulsions
___Developmental disabilities
___Temper outbursts/rage
___Death/Loss
___Loud, negative thoughts
___Domestic Violence

___Fears/phobias
___Chronic pain/Body pains or problems
___Suicide attempts/dates:_________
___Divorce or separation
___Problems with attachment
___Adoption
___Recent traumatic event
___Communication problems
___Losing time/blackouts
___Sleep too much
___Sleep too little
___Difficulty falling or staying asleep
___Recent traumatic event
___Fertility struggles
___Helplessness
___Feeling disconnected
___Life transition
___Seizures//PNES
___Epilepsy
___Emotional numbness
___Medical issues

___Nightmares
___Uncontrolled emotions
___Grief
___Gender Identity or Curiosity
___LGBTQ/exploration
___Transgender:_____________
___Problems with relationships
___Childhood neglect
___Substance abuse/overuse
___Self-soothing habits
___Obsessive/compulsive issues
___TBI/concussion
___Self-harming behaviors
___Sensory processing issues
___Separation anxiety
___Difficulty leaving house
___Body repetitive behaviors (skin picking, hair pulling, etc)
___Neurodivergence
___Autism Spectrum
___ADHD challenges
___PICA
___Postpartum
___Legal problems
___Other:

Client Signature: (By signing below I am stating that all above information I know to be true at this time):

____ ____________________
Client Signature **Date**