NEW DAY WOMEN'S CENTER

5575 Lake Park Way, Suite 106
La Mesa, CA 91942
(619) 713-1544

CLIENT INTAKE

Date:______________________________ Referred By:__________________________________

Interested in: Individual Counseling_________ Couples Counseling_________ Group Counseling__________

Support Group________ Mentoring__________ Workshops_________ Other_______________

Name:____ Phone: ______________________________

Address:____ Email: _______________________________

City: ____ Zip: _________________________________

Date of Birth:______________________________________ Age: _________________________________

Marital Status: ☐ Single/Never Married ☐ Single/Widowed ☐ Married ☐ Separated ☐ Divorced

Number in Household:_________ List Household Members (can continue on back of page if more space is needed):

Name: DOB: Relationship:

____

____

____

Reason for seeking counseling:____

____

Previous Counseling Experience (include name of counselor and dates of therapy):

Inpatient:____

Outpatient:____

Legal Involvement (Attorneys, Courts, CPS, etc.): Yes______ No_________ If Yes, please list:

Name:____ Phone Number:________________________

Demographic Information (optional) *Used for grant proposals, donor reports, and determining service/rates

Household Monthly Income:_______________________________ Insurance Info:__________________________

Age Range: ☐ 12-17 ☐ 18-25 ☐ 26-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+ Sex: ☐ M ☐ F

Race/Ethnicity: ☐ Middle Eastern/Northern African ☐ Black or African American ☐ Hispanic/Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian

Name of Client:____ **Date:**____________________

Are you currently under medical treatment? Yes No If yes, name of Doctor: ___________________________

Please describe any significant current or chronic diagnosed medical conditions___________________________

____

Are you currently taking any medication? Yes No (If yes, please list name & dosage):

____

Previous medications taken (Include dates):____

____

Any significant allergies? (Especially if drug related):_______________________________________

Do you have any physical complaints at this time?____

Is there any history of mental illness in your family? Yes No

If yes, please describe: ____

____

Circle the appropriate answer:

I drink alcohol:	Never	Seldom	Socially	To excess
My spouse drinks alcohol:	Never	Seldom	Socially	To excess

Is anyone in your family, past or present, an alcoholic or a problem drinker? Yes No (If yes, please explain):

Briefly describe any history of drug or alcohol abuse:____

____

Are you struggling with any habit that causes you to feel out of control? Yes No (If yes, please explain): ______

____

Have you ever had suicidal thoughts? Attempts? Yes No (If yes, please explain):_________________________

____

Are you experiencing any changes in eating? Yes No (If yes, please explain):

____

Are you experiencing any changes in sexual activity? Yes No (If yes, please explain):__________________

____

Are you experiencing any changes in sleep? Yes No (If yes, please explain):_______________________

____

Client Name:____ **Date:**__________________

Briefly describe the three most traumatic experiences of your life and how you were impacted by each:

1. ____

2. ____

3. ____

Give a brief history of relationship with:

Father: ____

Mother: ____

Brother/Sister: ____

Spouse/Partner: ____

Children/Step-Children:____

Spirituality:

Describe your religious or spiritual affiliation or orientation ________________________________

Do you regularly attend church?____

Name of church____

Are there any additional comments you would like to tell us about yourself?____________________