INTAKE /ASSESSMENT

_____Photocopy of Client/Guardian Identification _____Facility Consent for Service/Disclosure Statement
_____Photocopy of Insurance Card, if applicable _____Applicable Release of Information
_____Notice of Client Confidentiality/Facility Privacy Practices

I have completed the Intake and provided the above listed documents to Newlife Counseling Services, LLC.

Client/Guardian Signature Date 03/21/2020

Name (print)

_____ _____
Clinician Signature Date

Name (print)

How did you hear about Newlife Counseling Services, LLC
****

CLIENT INFORMATION

Please fill out this form as completely as you can. All information provided will be held in strict professional confidence unless otherwise directed by law or you with a completed and signed release of information form.

Name: Date of Birth:

Address:
Street City State Zip
Social Security No: Race/Ethnicity:

Home phone: Cell Phone:

Email: May we contact you via this email? No Yes

NOTE: Confidentiality cannot be guaranteed when communicating via cellphone, cordless phone, fax, email or internet. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when/where/ how to use those tools.

Where may we call you? Home Work Cell Can we leave message? Home Work Cell

How do you prefer to be contacted?

Emergency Contact (name/phone):

Please indicate relationship to you:
****

Health Insurance:

Primary Health Insurance Plan

Policy Holder's Name:

Insurance Plan ID #: Group ID #:

Policy Holder's Social Security #: Policy Holder's DOB:

Co-pay Amount: EAP Reference Number:

****

Evaluation:

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Marital Status: single married separated divorced
remarried engaged widowed cohabiting

If applicable, please complete the following:
Partner's Name: **Partner's Age**: Partner's Occupation:

Sexual Orientación: Heterosexual Homosexual Bisexual

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

In your own words, describe the current problems that brings you to counseling:

How long has this been going on?

What made you come in at this time?

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Would you like your cultural or spiritual beliefs considered in your therapy?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

Difficulty falling or staying asleep Difficulty getting out of bed Not feeling rested in the morning
Persistent loss of interest in previously enjoyable activities Withdrawing for other people
Depressed mood Rapid mood changes Anxiety Frequent feelings of guilt Irritability
Difficulty leaving your home Spending increased time alone Feeling Numb Panic Attacks
Avoiding people, places, activities, or specific things Repetitive behaviors (i.e. washing hands)
Outburst of anger Worthlessness Sadness Fear Hopelessness Helplessness Feeling or acting like a different person Change in eating/appetite Change in weight (1bs) Tremors
Nightmares Flashbacks Large gaps in memory Feeling outside yourself Persistent repetitive or intrusive thoughts Hear voices Difficulty solving problems Racing thoughts Concerns about your sexuality

Self-mutilation/cutting Thoughts of suicide Thoughts of harming others
Have you ever attempted suicide? No Yes
(Please describe below)

Do you have a history of harming others?

Have you seen mental health professional before? No Yes (if yes answer below)

Name of Mental Health Professional: Dates of treatment:
Reason for seeking help:

Are you currently taking psychiatric medication? No Yes **(if yes answer below)**

Medication Dosage How long have been taking it? Is it helpful?

Have you taken psychiatric medication in the past? No Yes (if yes answer below)

Medication Dosage How long have been taking it? Is it helpful?

Have you ever been hospitalized for a psychiatric reason? No Yes (if yes answer below)

Are you currently taking Non-psychiatric medication? No Yes **(if yes answer below)**

Medication Dosage How long have been taking it? Is it helpful?

Hospital Date: Reason:

Are you currently under treatment for any medical condition? No Yes (if yes explain below)

List any PRIOR illnesses, operations and accidents:

Family History:
Fathers age: Living Deceased Cause of death Age at time of death

Mother's age: Living Deceased Cause of death Age at time of death

Name and age of siblings: Are you close to him or her

During your childhood, did you live any significant period of time with anyone other than your natural parents? No Yes If so, please give the person and relationship to you
Reason:

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	**Brothers**	**Sisters**	**Father**	**Mother**	**Uncle/Aunt**	**Grandparents**
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Education:

Highest grade level completed: Degree obtained if applicable

Name of School/College:
Do you or did you have any disciplinary problems in school?
Were you consider hyperactive/ADHD in school No Yes If so, were you on medication No Yes
If yes, name of medication? What kind of grades do you get: A's B's C's D's F's
Did you have any developmental issues, concerns or delays as a child? (If so explain below)

Did your mother have any medical concerns while pregnant with you?

Have you ever served in the military? No Yes (if yes) Start date End date
Type of discharge/separation:

Employment:
Are you currently employed? No Yes (if so) What type of work do you do?
Most recent Job:

Legal History

Have you ever been arrested? No Yes (If yes describe)

List your religious affiliation: Cultural affiliation:
How would you like your religious and/or culture affiliations included in your treatment?

What type of social activities do you participate in?

Who do you turn to for help with your problems?

Have you ever been abused? Verbally Emotionally Physically Sexually Neglected

If so, please describe:

SUBSTANCE ABUSE:

Do you drink alcohol? No Yes If yes, age of first use:

How much do you drink? How often do you drink?

Have you ever passed out from drinking? No Yes how

SUBSTANCE ABUSE

Alcohol
Do you drink alcohol? If yes, age of first use

How much do you drink? How often?

Have you ever passed out from drinking? How often?
Have you ever blacked out from drinking? How often?
Have you ever had the "shakes"? How often?
Have you ever felt you should cut down on your drinking/drug use? How often?
Have people annoyed you by criticizing your drinking/drug use? How often?
Have you ever felt bad or guilty about your drinking/drug use? How often?
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?
If yes, how often?
Do you use tobacco? If yes, how often?

Other Drugs:

Please indicate for each drug listed below

Drug	**Ever Used?**	**Age at 1st use**	**Time Since Last Use**	**Approx. use in last 30 days**
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Trauma:

Have you ever experienced a trauma? No Yes If yes, how old were you?
Please describe the traumatic event(s)?

Clinician Signature _____ Date: _____

Print Name : _____