2755 E. Oakland Park Blvd, Suite 255, Ft. Lauderdale. FL 33306
info@treeoflifefl.com
954.947.0774

New Client Intake Form

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Name: ____

Address: ____

Phone Number(s): ___________________________ E-mail: ________________

DOB: _______________ Gender: ________ Referred by: _________________

1. Have you received any type of mental health services? □ No □ Yes

    If yes, which of the following:
    □ Psychotherapy □ Medication □ Outpatient Hospitalizations □ Inpatient Hospitalization

Please provide:
Name of provider or facility:_______ Location: ____
Dates of treatment: _______ Reason for treatment:_____

2. Briefly, what brings you in today?

3. When did your problem first start? Within the last:
    □ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

4. What areas of your life have been affected because of this problem?

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

   If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
   □ No □ Yes

   If yes, when did you begin experiencing this?

7. Please describe any major losses or traumas you have experienced:

8. What significant life changes or stressful events have you experienced recently?

9. What would you like to accomplish out of your time in counseling?

Family History

10. Where were you born?____

11. Where did you grow up? ____
    □ city □ suburbs □ country

12. Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

13. Who did you live with, growing up?_______________________________________

14. Mother's occupation: ____

15. Father's occupation:____

16. Please describe your family relationships:

____
____
____

17. In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please check	List Family Member
Alcohol/Substance Abuse	Yes □ No □	
Anxiety	Yes □ No □	
Depression	Yes □ No □	
Domestic Violence	Yes □ No □	
Sexual Abuse	Yes □ No □	
Eating Disorders	Yes □ No □	
Obesity	Yes □ No □	
Obsessive Compulsive Behavior	Yes □ No □	
Schizophrenia	Yes □ No □	
Suicide Attempts	Yes □ No □	

Other diagnosed mental health condition?	Yes □ No □	

18. Marital Status:
    □ Never Married
    □ Domestic Partner □ Married For how long?_____Please give partners name: __________
    □ Separated □ Divorced For how long? ___ □ Widowed: please give partners name, and year deceased: _______

    On a scale of 1-10 (10=best), how would you rate your relationship? _______

19. Are you currently in a romantic relationship? □ No □ Yes

    If yes, for how long? ____

On a scale of 1-10, how would you rate your relationship? __________________

20. Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

21. Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Prescribing provider and contact information:
Name: ____
Specialty: ____
Facility: ____
Phone, email, or Fax: ____

22. How would you rate your current physical health? (please check)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

23. Please list any specific health problems you are currently experiencing:

24. How would you rate your current sleeping habits? (please check)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

25. If you are having problems, in which phase of sleep? (please check)

□ Falling asleep □ Staying asleep □ Awakening early □ Sleep apnea

26. Please list any other specific sleep problems you are currently experiencing:

27. How many times per week do you generally exercise?

28. What types of exercise to you participate in?

29. Please list any difficulties you experience with your appetite or eating patterns:

30. Any change in weight over the past year? □ No □ Yes

31. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe ____

32. Please describe current use of alcohol, cigarettes, and/or recreational drugs:

33. Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

34. What is your current occupation? How many hours per week?

35. What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

36. What do you find particularly stressful about your current or previous work?

37. What do you enjoy doing in your free time? What do you do to relax?

38. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

39. What do you consider to be some of your strengths?

40. What do you consider to be some of your weaknesses?

41. Is there anything else you would like to share?