TIDES COUNSELING

NEW CLIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

Name: _____ Date: _____

DOB:_____ Age: _____ Gender: Male Female

Birthplace: _____ Religion (if any): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Do you reside in Florida ***seasonally*** or ***year-round*** (please circle)

Phone Number(s): _____

Do you authorize me to leave a voicemail? YES NO

Do you authorize me to send a text message? YES NO

Email: _____

Would you like to receive email communication? YES NO

How were you referred to my practice? _____

PAIGE E. FANT, LCSW, MCAP, ICADC
Provider NPI #1669960373
Florida License #SW15154

721 US Highway 1
Suite 205
North Palm Beach, Florida 33408
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PRESENTING PROBLEMS

Please describe the general nature of the problem(s) that bring(s) you into seeking treatment at this point in your life, and how long has this been an issue for you.

_____

_____

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

_____

Have you had therapy in the past? If so, with whom, where and for what duration?

_____

_____

_____

MEDICAL & WELLNESS INFORMATION

Are you currently or have you ever received psychiatric services before? YES NO

If no, are you interested in a referral for psychiatry? If yes, when, with whom, and please list current psychiatric medications prescribed:

_____

_____

_____

Have you ever had an adverse reaction to any psychotropic medication? YES NO

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If yes, please describe: _____

Do you have any current or past traumatic medical issues, hospitalizations, accidents, injuries or surgeries? If yes, please describe:

_____

_____

_____

In the past year, have there been any significant changes in your life? (i.e. moves, appetite, sleep, health, family, memory, concentration, unusual thoughts, overall functioning)?

_____

_____

_____

SAFETY ASSESSMENT & PLANNING

Are you currently having any suicidal thoughts or plans to self-harm? YES NO

If yes or if so at any time in the future, immediately dial 911, the National Suicide Prevention Lifeline at 1-800-273-8255, the mobile crisis unit 561-637-2101, or visit your nearest ER for stabilization. If you are not currently having suicidal thoughts but they arise in the future, please acknowledge that it is part of your responsibilities to inform me of any changes herein. Please sign below to acknowledge that you understand and accept these terms.

_____
Printed name

_____ _____
Signature Therapist Signature

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Have you ever had suicidal ideation? YES NO
If yes, please explain:

_____

_____

_____

Have you ever planned or attempted to hurt yourself? YES NO
If yes, please explain:

_____

_____

_____

Have you ever planned or attempted to seriously hurt or harm someone else? YES NO
If yes, please explain:

_____

_____

_____

Do you have any weapons in your home, access to weapons, or possess a stash of medication that you could use for lethal means? YES NO

If yes, who has access to them and what are the safety protocols around them?

_____

_____

_____

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Have you ever been hospitalized for psychological issues? If yes, please describe:

_____

_____

_____

Please describe your drug and alcohol use past and present. Have you even participated in a drug or alcohol treatment or detox program? Have you in the past or do you currently attend AA, NA, ALANON or any other recovery groups? (remember, this is confidential)

_____

_____

_____

Are you currently using any illegal drugs or prescription medications in a way other than prescribed? Is the reason you are seeking therapy services substance related? If so, please elaborate:

_____

_____

_____

Do you currently smoke cigarettes or use other tobacco/nicotine products? YES NO
If yes, would you like to quit? YES NO

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything related to past painful experiences? If so, please explain:

_____

_____

_____

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Is there any history past or present of abuse or violence? YES NO
If so, please explain:

_____

_____

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain:

_____

_____

CAREER, EDUCATION, LEISURE

What is your current occupation? If retired, what was your primary occupation and when did you retire? How would you describe your personal fulfillment in your job/career?

_____

_____

_____

Please outline your educational background and field of study.

_____

_____

INTIMATE RELATIONSHIPS

If you are currently in a relationship, please describe your relationship. If you are not currently in a relationship, please describe your most recent relationship if any. What is your current marital status? Would you like to change anything about your current relationship status?

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_____

_____

_____

How would you describe your communication with your partner or previous partners?

_____

_____

_____

How would you describe your sexual intimacy with your current or past partners?

_____

_____

FAMILY

Where were you raised primarily and who served as your primary caregiver? In general terms, how would you describe your childhood?

_____

_____

_____

Parent's marital status:
Married Divorced Never Married Separated Domestic Partners Widowed

Please briefly describe your relationship with your parents:

_____

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_____

_____

Please list other significant family members?

Name Relationship Age Occupation Location

_____

_____

_____

Have you had any recent or significant losses of a loved one? If yes, please describe:

_____

_____

_____

Has anyone in your family suffered from mental illness or alcohol/drug abuse?

_____

_____

Do you have children? If yes, please list name/age/occupation and whether you feel a close bond:

_____

_____

With whom do you currently reside? Feel free to include your pets if appropriate.

_____

FRIENDS & SUPPORT

How many people would you consider close friends in your life?

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_____

_____

_____

Do you belong to any social groups or religious/spiritual organizations that serve as support systems? If yes, please describe your level of involvement:

_____

_____

Have you had any recent problems or serious conflicts with any family, friends, co-workers, neighbors or other people you encounter in everyday life? If yes, please describe:

_____

_____

_____

Please list anything else not covered in the questions above that you feel is important for me to know about you or your situation.

_____

_____

_____ _____

Printed name Date

_____ _____

Signature Therapist Signature

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