



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

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Suite 100C
Palm Beach Gardens, FL 33410
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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

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

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?

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:

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?

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:

Please list other significant family members?

Name	Relationship	Age	Occupation	Location
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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?

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