CLIENT INTAKE FORM

Red Bank Counseling, LLC

130 Maple Avenue, Suite 3D

Red Bank, New Jersey 07701

732-747-9221

info@redbankcounseling.com

Date of first appointment:

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.

Referred by:

- ☐ Medical Provider: _____
- ☐ Insurance Provider: _____
- ☐ My Website: https://redbankcounseling.com
- ☐ PsychologyToday
  Friend/Family: _____
- ☐ Other: _____

Have you ever received any psychiatric or psychological help/counseling of any kind before? If so, please explain.

- ☐ _____

Briefly describe your reason for seeking help at this time:

- ☐ _____

Please circle any of the following that pertain to you:

Nervousness Depression

Fear

Shyness Sexual Problems

Suicidal Thoughts

Separation Divorce

Finances

Drug Use Alcohol Use

Friends

Anger Self Control

Unhappiness

Sleep Stress

Work

Relaxation Headaches

Fatigue

Legal Matters Memory

Ambition

Energy Insomnia

Decision Making

Loneliness Inferiority

Feelings Concentration

Education Career Choices

Illness Problems

Temper Nightmares

Marriage

Children Appetite

Bowel or Stomach Trouble

Self Esteem Parenting

My Thoughts

Pain Grief

Feeling Empty

Shopping/Spending Patterns
Organization

Health Concerns

Other:_____

Family History

Where were you born? _____

Where did you grow up? _____

☐ City
☐ Suburbs
☐ Country

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

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

Who did you live with while growing up? _____
Mother's occupation: _____
Father's occupation? _____

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 circle	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 Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:
☐ Never Married
☐ Domestic Partner
☐ Married
☐ Separated
☐ Divorced -- For how long?
☐ Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name: _____

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

Are you currently in a romantic relationship?
☐ Yes -- How long? _____

☐ No

On a scale of 1-10 (best), how would you rate your relationship? _____ Please list any children, their names, and ages:

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

Physical Health

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	Date Began/Stopped

Prescribing provider and contact information:

Name:
_____

Specialty:
_____

Facility:
_____

Phone, email, or Fax:
_____

☐ How would you rate your current physical health?
☐ Poor

☐ Unsatisfactory
☐ Satisfactory
☐ Good
☐ Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

☐ Poor
☐ Unsatisfactory
☐ Satisfactory
☐ Good
☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

☐ Falling asleep
☐ Staying asleep
☐ Awakening early
☐ Sleep apnea

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

How many times per week do you generally exercise? _____ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

☐ No
☐ Yes

If yes, please describe:

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

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

Additional Information

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

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

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

What gives your life meaning?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

How can your beliefs, values, or
practices help you overcome the problems that bring you to treatment?

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

Please add any additional information that you believe may be useful:

Thank you for completing this questionnaire. The information you have provided will be helpful in planning the best possible treatment. As with other information you may share with me, the information contained on this form will be treated with confidentiality.