



### NEW CLIENT INTAKE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Apt or Box #: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Work: Full-Time Part-Time Student Stay at Home Parent Unemployed Disabled Retired

Employer: \_\_\_\_\_

#### CONTACT

Email: \_\_\_\_\_ May I send you information at this email? Yes No

Phone: \_\_\_\_\_ May I call or leave a message at this #? Yes No

#### INSURANCE

Date of Birth of Insured: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ Primary Insurance: \_\_\_\_\_

#### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

I give consent to contact the above listed person in the event of an emergency Yes No

I give the consent to contact the above listed person to coordinate my care Yes No

#### HOME LIFE

Marital Status: Never Married Divorced Widowed Separated Other: \_\_\_\_\_

How many people live in your home? (Include yourself) \_\_\_\_\_

Name/ Age \_\_\_\_\_ Name/ Age \_\_\_\_\_

Name/ Age \_\_\_\_\_ Name/ Age \_\_\_\_\_

#### REFERRAL

Mental Health Substance Use Domestic Abuse Name of referral: \_\_\_\_\_

Referred by: Self Hospital Family Friend School Court Physician PO

#### COMPLAINT Current Symptoms:

Anxiety Appetite Issues Avoidance Crying Spells Depression Excessive Energy Fatigue Guilt  
Hallucinations Impulsivity Irritability Libido Changes Loss of Interest Panic Attacks Racing Thoughts  
Risky Activities Sleep Changes Suspiciousness Other Symptoms: \_\_\_\_\_

Briefly describe what brings you to Credo Counseling, LLC \_\_\_\_\_

\_\_\_\_\_

**HISTORY**

Have you received mental health treatment and/or been inpatient for mental health treatment? Yes No  
If so, Where \_\_\_\_\_ When: \_\_\_\_\_

**Have you ever tried the following:**

Alcohol Pain Killers Marijuana Synthetic Drugs Stimulants Hallucinogens Heroin Ecstasy  
Methamphetamine Cocaine Methadone Tranquilizers Inhalants Tobacco

Other: \_\_\_\_\_

If yes to any please list frequency of use: \_\_\_\_\_

Have you ever been treated for drug or alcohol addiction? Yes No When? \_\_\_\_\_

Have you ever abused prescription medications? Yes No Which ones: \_\_\_\_\_

Do you give permission for us to contact your primary care physician? Yes No

If you decline, Please give specific reason for your denial: \_\_\_\_\_

**FAMILY HISTORY**

How is your relationship with your mother? Great Good Fair Poor Very Bad Deceased

How is your relationship with your father? Great Good Fair Poor Very Bad Deceased

Are your parents? Married Divorced Your age at divorce? \_\_\_\_\_ Did parents remarry? Yes No

Family members with Medical or Mental Health Conditions? \_\_\_\_\_

Were you adopted? Yes No Age of adoption? \_\_\_\_\_

Have you or your family member attempted or completed suicide or engaged in self harm? When? \_\_\_\_\_

Who? \_\_\_\_\_

Have you experienced Neglect, Abuse, or Trauma? By Who? Please describe: \_\_\_\_\_

**CURRENT SITUATION**

Highest level of Education? \_\_\_\_\_ Have you ever served or currently serve in the military? Yes No

What Branch? \_\_\_\_\_

Married/Committed Relationship How long? \_\_\_ Divorced? Yes No Sexually active? Yes No

Relationship with partner/spouse? Great Good Poor Very Bad Do you have Children? Yes No

Relationship with children? Great Good Poor Very Bad Have you ever been arrested? Yes No

When/ Why? \_\_\_\_\_

**MEDICAL HISTORY**

Current Medications (Include non-prescription, herbal medicines, and supplements):

\_\_\_\_\_

Who prescribes your medications? \_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Credo Provider: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_