CREDO
Counseling, LLC

credocounseling.com
4828 E. 57th St #3 Sioux Falls, SD 57108
P 605.906.2520 F 605.741.8170

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: _____/_____/_____