INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

CLIENT ID# _____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

(☒ your concerns)

I AM EXPERIENCING...	Seldom	Often	Always	Never	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING...	Seldom	Often	Always	Never	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE...	Seldom	Often	Always	Never	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

CLIENT ID# _____

I HAVE...	Seldom	Often	Always	Never	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE...	Seldom	Often	Always	Never	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

I USE THE FOLLOWING....	Seldom	Often	Daily	Never	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES...	Seldom	Often	Always	Never	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

I HAVE...	Seldom	Often	Always	Never	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF-CARE	Seldom	Often	Always	Never	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

CLIENT ID# _____

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness? ☐Yes ☐No

Has a close relative ever been hospitalized for a psychiatric illness? ☐Yes ☐No

Does anyone in your family have a mental illness? ☐Yes ☐No

Has anyone in your family every attempted or committed suicide? ☐Yes ☐No

Does anyone in your family have a substance abuse problem? ☐Yes ☐No

Have you ever been arrested? ☐Yes ☐No

1) How well you are doing on your job: (☐)

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

2) How well you are doing in your marital/significant other relationship:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

3) How well you are doing in your family relationships:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

4) How well you are doing in relationships with people outside your family:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

5) Please rate your current physical health:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

6) Please rate your general happiness and well-being:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									

Monica Dahling New, M.A.
225 North Mill street #202
Aspen, Co 81611

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee session is charged for *missed appointments* or *cancellations* with *less than* a *48-hour notice* unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date