

Please note: You are free to skip any questions which you prefer not to answer.
If additional space is needed, please use the back of this form.



PSYCHOLOGICAL & COUNSELING SERVICES, PC

Offering a Full Range of Psychological & Counseling Services

12728 Augusta Avenue, Suite 150 Omaha, NE 68144 (402)330-1537

NEW CLIENT INTAKE FORM (ADULT)

PLEASE PROVIDE THE FOLLOWING INFORMATION. CHECKMARK ANY ITEMS YOU DON'T WANT TO ANSWER.

TODAY'S DATE: _____

CLIENT NAME: _____

DATE OF BIRTH: _____

HOME ADDRESS (INCLUDE ZIP): _____

PREFERRED CONTACT NUMBER: _____ LEAVE MESSAGES AT THIS NUMBER? Y N

ALTERNATE CONTACT NUMBER: _____ LEAVE MESSAGES AT THIS NUMBER? Y N

RACE/ETHNICITY: _____

RELIGIOUS IDENTIFICATION (IF ANY): _____

EDUCATION: _____

PLACE OF EMPLOYMENT: _____

POSITION: _____

HOW LONG HAVE YOU WORKED THERE? _____

WORK PHONE: _____

IF UNEMPLOYED, DATE AND PLACE OF LAST EMPLOYMENT: _____

RELATIONSHIP STATUS: MARRIED PARTNERED DATING NOT DATING DIVORCED/ SEPARATED

NAME OF PARTNER/ SPOUSE: _____ DURATION OF RELATIONSHIP: _____

CHILDREN (NAMES, AGES, EDUCATION STATUS): _____

CUSTODY STATUS (IF APPLICABLE): _____

LIST EVERYONE WHO LIVES AT YOUR HOME: _____

PRESENTING PROBLEM/ REASON FOR APPOINTMENT: _____

HAVE YOU EVER SOUGHT HELP FOR THIS CONCERN BEFORE? IF SO, WITH WHOM? WHEN? _____

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FAMILY OF ORIGIN

PLACE OF BIRTH: _____ WHERE DID YOU GROW UP? _____
AGE MOVED OUT/ LEFT FAMILY: _____
LIST ANY SIBLINGS (NAME, AGE, CITY OF RESIDENCE): _____
PARENTS' NAMES, AGES (IF DECEASED, PLEASE NOTE YEAR): _____
ANY SIGNIFICANT TRAUMA GROWING UP? _____
PHYSICAL ABUSE? _____ SEXUAL ABUSE? _____ DOMESTIC VIOLENCE BETWEEN PARENTS? _____
COMPLICATIONS WHEN YOU WERE BORN/ YOUR MOTHER WAS PREGNANT WITH YOU? _____
ANYTHING UNUSUAL ABOUT YOUR CHILDHOOD DEVELOPMENT? _____
FAMILY MEDICAL CONCERNS? _____

ACADEMIC HISTORY

HIGHEST LEVEL/ DEGREE ACHIEVED: _____ INSTITUTION ATTENDED: _____
HIGH SCHOOL GRADE POINT AVERAGE (IF UNKNOWN, ESTIMATE): _____
WHAT WAS SCHOOL LIKE FOR YOU? _____
ANY HISTORY OF ATTENTION OR BEHAVIOR PROBLEMS? _____
ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES? _____
FAMILY ACADEMIC/ LEARNING PROBLEMS? _____

MEDICAL HISTORY

CURRENT MEDICATIONS, REASON TAKING, PRESCRIBING DR.: _____
CHRONIC ILLNESSES? _____
CURRENT MEDICAL CONCERNS? _____
SURGERIES PAST, PLANNED? _____
EMERGENCY ROOM TRIPS? _____

PSYCHIATRIC HISTORY

PRIOR COUNSELING, CLINICIAN SEEN: _____
CURRENT OR PAST PSYCHOTROPIC MEDICATIONS: _____
HOSPITALIZATIONS/ TREATMENT STAYS (DATE, LOCATION): _____
PAST DIAGNOSES: _____
PAST SUICIDE ATTEMPTS: _____

LEGAL HISTORY

PAST LEGAL CHARGES/ CONVICTIONS: _____
PENDING CHARGES: _____
CURRENT DIVORCE/ CUSTODY ACTIONS (INCLUDE WHEN INITIATED AND BY WHOM): _____
CHILDHOOD LEGAL DIFFICULTIES: _____
CHILDHOOD CONDUCT PROBLEMS (fighting, lying, stealing): _____

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SYMPTOM CHECKLIST

Place a check mark next to the symptoms that you are experiencing. For EACH symptom checked, please note the severity (1-10 from least to most problematic) and how long you have been experiencing this.

- Depressed mood
- Feeling hopeless
- Social withdrawal
- Lack of interest in previously enjoyed activities
- Changed sleep patterns (too much or too little)
- Changed appetite (too much or too little)
- Difficulty concentrating
- Irritability

- Obsessive thoughts
- Social anxiety
- Panic attacks (check relevant symptoms):
 - palpitations, pounding heart, or accelerated heart rate
 - sweating
 - trembling or shaking
 - sensations of shortness of breath or smothering
 - feeling of choking

- Careless, poor attention to details
- Difficulty sustaining attention
- Unable to listen to others
- Difficulty organizing
- Tend to avoid effortful tasks
- Often lose necessary things
- Easily distracted

- Fatigue
- Thoughts of suicide
- Mood swings
- Recklessness
- Thoughts of suicide
- Suicide attempts
- Self-harm (cutting, self-mutilating)
 - chest pain or discomfort
 - nausea or abdominal distress
 - feeling dizzy, unsteady, lightheaded, or faint
 - feelings of unreality or being detached from oneself
 - fear of losing control or going crazy
 - fear of dying
 - numbness or tingling sensations
 - chills or hot flashes

- Forgetful in daily activities
- Fidgety, unable to sit still
- Always on the go
- Acts as if driven by motor
- Talking excessively
- Difficulty waiting turn
- Impulsive/ acts without thinking first

Substance Use (what used, how much, last time used): _____

Other symptoms not noted above: _____
