


David Ashburner

When it's time to get your life  Gear...



NEW CLIENT INTAKE INFORMATION		Date:
Name:	Date of Birth:	Age:
Address:		City, State, Zip:
Phone where I can call you: (Home)	(Work)	(Cell)
Email Address where I can reach you:		
Occupation:	Education:	
Employer:		
Address:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Co-Habiting		
Significant Others Name:		Age:
Occupation:	Employer:	
Names & Ages of Children:		
Number of Marriages & Length of Each:		
Religious Practice As A Child:		As An Adult:
Name of Current Place of Worship:		
Name of Emergency Contact:		
Phone:	Relationship:	
Address:		
How did you find David? Check all that apply.		
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Employer <input type="checkbox"/> Pastor <input type="checkbox"/> Physician <input type="checkbox"/> Brochure <input type="checkbox"/> Psychology Today <input type="checkbox"/> Google/web search <input type="checkbox"/> Theravive <input type="checkbox"/> Network Therapy <input type="checkbox"/> Other: Please explain _____		
Please summarize the issues for which you are seeking help. If there is more than one reason, rank them in order.		
1)		
2)		
3)		
4)		
Circle the number that represents the severity of your concerns.		
Not Severe	1	2
	3	4
	5	Very Severe

Family of Origin (Parents, Siblings):

Name _____

Age _____

Relationship _____

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental health issue? Please explain.

Physicians Name:

Phone:

Date of last Physical:

Please list any medical treatments & operations within the last year:

Please list all current illnesses: (allergies, ulcers, tensions, back problems, diabetes, etc.)

Please list any prescription medications you have taken within the last six months, circle current medications:

Have you had any prior personal counseling? ____ Yes ____ No (If yes, please list counselor, dates, and addresses)

Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency, etc.?

____ Yes ____ No (If yes, please list hospital, doctor's name and dates with a brief explanation)

Have you ever considered or attempted suicide? Please explain briefly.

Have you ever been sexually, physically, or emotionally abused? If so, by whom and how long ago?

Check any of the following problems that apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Bowel disturbances |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sedative use | <input type="checkbox"/> Problem with alcohol | <input type="checkbox"/> Tension/anxiety |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Tremors | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Drug use | <input type="checkbox"/> Difficulty relaxing |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Lack of enjoyment in life | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Difficulty keeping a job | <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Legal Matters |
| <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Poor home environment | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Educational difficulties | <input type="checkbox"/> Feelings of loneliness | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Problems with children | <input type="checkbox"/> Self-control problems | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Career Choices | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Distractibility |
| <input type="checkbox"/> Binge/Vomit/Laxative Use | <input type="checkbox"/> Loss of time/blackouts | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Difficulty sitting | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Divorce | <input type="checkbox"/> Separation |

Briefly list what you think are your personal strengths and weaknesses. Think in terms of your personality, work habits, intellectual capabilities, and other skills or talents.

Strengths

Weaknesses

What else should you let me know about?