David Ashburner

When it's time to get your life InGear…

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: ___ Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed ___ Co-Habitating	
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.

_____ Self _____ Parent _____ Friend _____ Employer ____ Pastor ____ Physician ____ Brochure

_____ Psychology Today _____ Google/web search _____ Theravive _____ Network Therapy

_____ 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:

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