Confidential New Client Intake

Welcome to Glynn Griggs Counseling. I want to make the most of each appointment you have with me. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the the following fields as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

First Name_____Preferred Name_____Last Name_____

Address_____City_____Zip_____

Preferred Contact # ( )_____ -_____ Email_____

- ✳ Permission is granted to leave voice messages (___Yes or ___ No)
- ✳ Permission is granted to send text messages (___ Yes or ___ No)
- ✳ Permission is granted to send messages to email (___ Yes or ___ No)

Age_____Birth Date_____/_____/_____ Gender Identity (circle) M F NB Other_____

Emergency Contact Name_____Number ( )_____-_____

Spouse/Partner Name_____Age_____Years in Relationship____ Satisfaction with Relationship (circle) **Good Okay Poor**
Do you have any children? (circle) Y N

Check all that you are *currently* experiencing:

- ▫ Abuse
- ▫ Anger
- ▫ Anxiety
- ▫ Body Image Issues
- ▫ Compulsions
- ▫ Drug/Alcohol Abuse
- ▫ Difficulty Concentrating
- ▫ Difficult Making Decisions
- ▫ Eating Problems
- ▫ Excessive Irritability
- ▫ Loneliness
- ▫ Grief
- ▫ Guilt/Shame
- ▫ Hallucinations
- ▫ Infidelity
- ▫ Panic Attacks
- ▫ Phobias
- ▫ Problems at Work/School
- ▫ Relationship Problems
- ▫ Sadness/Depression
- ▫ Self-Esteem Issues
- ▫ Sexual Problems
- ▫ Stress
- ▫ Suicidal Thoughts/Feelings/Actions
- ▫ Thoughts about Sexuality
- ▫ Thoughts about Sexual Orientation
- ▫ Thoughts about Gender
- ▫ Trouble with Family
- ▫ Trouble with Friends
- ▫ Codependency

▢ Aging/Dependency
▢ Divorce/Separation
▢ Singleness
▢ God/faith concerns
▢ Other _____
▢ Other _____

Current Medications

Medication	Dosage	Reason for Medication

Have you recently ceased taking any medication? ___ Yes ___ No If yes, please list below and give reason for stopping the medication.

Diagnoses given by other doctors, psychiatrists, psychologists, or therapists:

_____

Substance Use

If you currently consume alcohol, how many drinks per occasion do you consume?_____
How many times per week do you consume alcohol?_____

Check all that apply:

▢ I have a history of problematic use of alcohol.
▢ Others have expressed concern with my alcohol consumption.
▢ I currently use non-prescribed drug or street drugs (i.e. marijuana, cocaine, and methamphetamine).
▢ I have a history of problematic use of prescription &/or non-prescription drugs.
▢ I have a family history of addiction.

Trauma

Have you experienced trauma in your life? (circle) No ___ Yes ___
If yes, please explain:

_____

_____

Family Mental Health

In the section below, identify if there is a family history of any of the following. If yes, indicate the family member's relationship to you in the space provided (Father, Mother, Grandmother, Grandfather, etc.):

▢ Addiction _____
▢ Anxiety _____
▢ Bipolar _____
▢ Depression _____
▢ Domestic Violence _____
▢ Eating Disorders _____
▢ Schizophrenia _____
▢ Suicide Attempts _____

Harmful Behaviors

▢ Current Self-Harm
▢ History of Self-Harm
▢ Current Suicidal Feelings
▢ History of Suicidal Feelings
▢ History of Suicide Attempts
▢ Current Homicidal Feelings
▢ History of Homicidal Feelings

Relationship Quality & Status

If you are currently in a relationship, what is your relationship status? (circle)

Married Boyfriend/Girlfriend Domestic Partner Separated Divorced

How do you rate your relationship? (1 = bad, 5 = neutral, 10 = great) _____

Additional Information

Education: _____

Occupation: _____

How do you rate your job satisfaction? (1 = bad, 5 = neutral, 10 = great) _____

If you consider yourself spiritual or religious, please circle your faith/belief.

Protestant Catholic Jewish Muslim Buddhist Hindu Spiritual Atheist Agnostic Other

Briefly describe your faith/spiritual beliefs_____

_____

Please describe your diet:

_____

_____

Please describe your sleep patterns, including amount and times:

_____

Prior Counseling

Have you had any prior counseling?

Yes ___ No ___ If yes, When?_____ Where?_____

With whom? _____

Why? _____

What was most beneficial about your counseling experience? _____

_____

Are you or another family member currently seeing a psychiatrist or another counselor?

Yes ___ No ___ If yes, who is in therapy? _____

Name of counselor _____

For what purpose? _____

Please List Three Things You Would Like to Accomplish in Counseling:

1. _____
2. _____
3. _____

I have answered to the best of my ability and certify that my answers are accurate to the best of my knowledge.

Signed _____ Date _____

Print Name _____

Thank you for taking the time to fill out the information in this form. I will maintain the strictest confidence regarding this information.