David Schaublin, LCSW
New Client Intake Form

Name: _____

Name of parent/guardian (if you are a minor):

_____

Birth Date: _____ /_____ /_____ Age: _____

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____

_____

CONTACT INFORMATION:

Home Phone: ( ) _____ May I leave a message? □ Yes □ No
Cell/Other Phone: ( ) _____ May I leave a message? □ Yes □ No
May I send a text message? □ Yes □ No
E-mail: _____ May I email you? □ Yes □ No
*Please note that emails and text messages may not be confidential

Emergency Contact Name and Number:_____

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
□ No □ Yes If yes, where:_____

Have you had previous psychotherapy?
□ No □ Yes If yes, previous therapist's name:_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□ No □ Yes If yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□ No □ Yes If yes, please list: _____

HEALTH INFORMATION:

1. How is your physical health at present?
Please circle: Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep