

**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