



New Client Intake Form

1 PERSONAL INFORMATION

Legal First name: Preferred Name:	Last name:
Age:	Date of birth:
Ethnicity:	Religion:
Marital status:	Number of children and their ages:
Sex/gender/pronouns:	Home address & Phone number:

Who do you live with & who supports you?

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2 EMPLOYMENT INFORMATION

Are you currently working? Full-time/ part-time/ Sick leave/ Retired/ N/A?

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3 REASON FOR CHOOSING THERAPY/ ME

How did you find out about me?

4 REASONS FOR SEEKING HELP

How intense is your emotional distress? (0 is not at all & 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Functioning: To what degree do your problems affect your ability to perform at work, at home, and in your relationships with others? (Where 0 is not at all & 10 is incapacitating)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When did these problems begin, and what was happening in your life at that time? What are the reasons for your visit today? Have these issues been persistent for awhile or a new, recent thing?



5 PSYCHIATRIC AND MEDICAL HISTORY

Have you been diagnosed with any psychiatric or mental health problems? Have you been diagnosed with any physical health problems?

Are you on any medication, and what for?

Please provide the name of your family doctor and contact details &
Please provide the name of your psychiatrist & contact details:

Complaints:

Texas Behavioral Health Executive Council (BHEC)
1801 Congress Avenue, Suite 7.300, Austin, TX 78701
(512) 305-7700 | www.bhec.texas.gov

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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