Kristin Burns, LCSW, SEP, RYT, AOBTA CP, RMT
715 Lake St, Suite 700
Oak Park, IL 60301

NEW CLIENT INTAKE

Date: ____
Patient Name: ____
Preferred Pronoun: ____
Social Security Number: ____
Date of Birth: ____
Gender: ( ) Male ( ) Female ( ) Transgendered ( ) Gender Fluid ( ) Other ___________
Home Address: ____
Home Phone Number:____________________ May we leave a message? [ ] Yes [ ] No
Work Phone Number: ____________________ May we leave a message? [ ] Yes [ ] No
Mobile Phone Number:____________________ May we leave a message? [ ] Yes [ ] No
Email Address: ____
If the above patient is a minor complete the following:
Name of Guardian: ____
Address of Guardian: ____
Guardian's Home Phone: __________________May we leave a message? [ ] Yes [ ] No
Guardian's Work Phone: ___________________May we leave a message? [ ] Yes [ ] No
Guardian's Mobile Phone: _________________May we leave a message? [ ] Yes [ ] No

If you will be using insurance to cover your sessions or a portion of the cost please complete the following:
Primary Insurance Company: ____
Insurance Phone Number: ____
Name of Primary Insured: ____
Address if Different from Client: ____
ID #:______________________________ Group #: ___________________________

Referral Source
Who referred you to my office, or how did your learn about my practice?_____________
Emergency Contact Information:
In case of an emergency, who should we contact?
Name: ____
Relationship: ____
Address: ____
Phone Number: ____

History Information
Who is providing the history information?

[ ] The patient
[ ] The patient's guardian
[ ] Other

What brings you to therapy now?

____

____

____

Check all words/phrases that describe what you are experiencing and explain if possible.
[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic Attacks
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tensions, aches, etc.
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated

[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:
____
____
____

Previous Treatment
Have you received or participated in previous counseling and/or therapy?
[ ] Yes [ ] No
If yes, with whom?: ____

Additional Information:
What did you like/dislike about previous treatment?
____
____
What did you learn about yourself through previous counseling/treatment that may help you? ____
____

Is there any type of treatment you would like to continue? ___________________________
____

Have you had hospital stays for psychological concerns?
[ ] Yes [ ] No

Additional Information:
Are you currently experiencing thoughts of harming either yourself or someone else?
[ ] Yes [ ] No
Have you in the past experienced thoughts of harming either yourself or someone else?
[ ] Yes [ ] No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?
[ ] Yes   [ ] No
If yes, explain:
Did you walk, talk, and read on time?
[ ] Yes [ ] No
Explain: ____
Do you feel you have completed life milestones (school, career, marriage, children, etc.) at appropriate times? ____
Are you satisfied at where you are in your life? ______________________________
If not, where would you like to be? ____
____

Medical History
List any current or important past medications
Medication & Dose: _______________________________
Response to Medication: ____________________________
History of serious childhood illnesses: ______________________________________
____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: ____
____

Have you experienced any head injuries?
[ ] Yes [ ] No
Important Details:
If yes, did you lose consciousness?
[ ] Yes   [ ] No
Have you experienced convulsions or seizures?
[ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No
Explain any allergies you have:
____
____

How would you rate your current physical health?
[ ] Excellent
[ ] Very Good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Very Poor
What was the date of your last physical or routine health “check up?”

Do you have a primary care physician?
[ ] Yes [ ] No
If yes, complete the following:
Name ____
Address ____
Phone Number ____

Family History

Birth Location: ____
Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father
[ ] Other: ____
Relationship with parent figures:
(good, fair, poor, close, distant, etc.)
Mother: _______________________
Father: ________________________
Step-parent: _____________________
Other: __________________________
List your siblings and describe your relationship with them?
Name: ____
Age: ____
Gender: ____
Nature of Relationship: ____________________________________
Any history of neglect, and/or physical, verbal, emotional, or sexual abuse?
____
Any family history of substance abuse, mental illness, suicide, or violence?
____

Any Additional Family Information: ___________________________
____

Social History

Describe your relationship with peers and/or friends?
____

How would you describe your social support network?
____
Describe your hobbies/interests:
____
Describe any cultural concerns:
____

Educational History

When attending school where you:

[ ] In regular classes
[ ] Home Study
[ ] Special classes
[ ] Advanced classes
[ ] Ever suspended
[ ] Placed in alternative school
What is the highest educational level you have completed? ________________________
Give any additional important educational information (i.e. Did you like school? Have a learning disability?) ____

Occupational History
What is your current employment status?
[ ] Employed Full-Time
[ ] Employed Part-time
[ ] Unemployed
[ ] Self-employed
[ ] Student
[ ] Other
Are you satisfied with your employment?______________________________________
If not, why? ____

Marital History
Which best describes your marital status?
[ ] Married, Date: ______
[ ] Domestic Partnership
[ ] Widowed, Date: _____
[ ] Separated, Date: _____
[ ] Divorced, Date:_______
If you are married, please briefly describe nature of your marital relationship:
____

If you are married, which best describes your marital satisfaction?
[ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:
Name ____
Date ____
Nature of Relationship ______________________________
Do you have children?
[ ] Yes [ ] No
If yes, complete the following:
First Names: ____
Ages: ____

Genders: ____
Nature of Relationships: ____

Are there presently any child custody issues involving you or your family?
[ ] Yes [ ] No
Does your family currently have Child Protective Services Involvement?
[ ] Yes [ ] No
If yes please complete the following:
Case Worker's Name: ____
Phone: ____

Substance Abuse History
Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)
[ ] Yes
[ ] No
If you answered yes, please complete the following:
Substance: ____
Age of First Use: ____________________
Frequency of Use:
(Daily, Weekly, Monthly)
Amount Used: _______________________
How did you use it? (smoked, injected, etc.) _____________________________________
Complete the following if you have ever received treatment for a substance abuse issue.
Name of Treatment Program: ____
Type of Treatment (please circle) (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)
Date of Treatment (Month, Year): ____
Outcome (Any Clean time?): ____

Legal History
Do you currently have any pending criminal charges?
[ ] Yes [ ] No
Are you on probation?
[ ] Yes [ ] No
Name of Probation Officer and County: ______________________________________
Have you ever been arrested/convicted of a crime?
[ ] Yes [ ] No: If yes:
List any Arrests/Convictions: ____
Date of Arrests/Convictions: ____
Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

Additional Information

Summarize your goals for therapy: ____

____

How would you know you made progress towards your goals?

____

____

____

What are your strengths? ____

____

What parts of yourself would you like to see improve?

____

____

Is there any additional information that you believe it is important for me to know in order to provide you with the best care possible? ___________________________________

____

_______________________________________ _________________________________

Signature of Client Date

_______________________________________ _________________________________

Signature of Guardian (if client is a minor) Date