Heike Zelnhefer, LCSW
New Client Intake Record

As a new client, please complete the information below to the best of your ability. The information you supply will enable me to provide a more effective service.

Part 1. Basic Information About You

Last Name: _____ **First Name:** _____ **Middle Name:** _____

For Transgender or Gender Fluid Individuals ONLY

How would you like to be called? _____

Age: _____ **Date of Birth:** _____ **Place of Birth:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email address: _____ May I send an email? ☐ Yes ☐ No

Phone Number: _____ May I leave a message? ☐ Yes ☐ No

Who were you referred by? _____

Emergency Contact (Name & Relationship): _____

Emergency Contact (Phone number): _____

Part 2. Family Information

Marital Status ☐ Single ☐ Married since: _____ ☐ In a Relationship since: _____
☐ Divorced since: _____ ☐ Widowed since: _____

If single, have you ever been in a relationship? ☐ Yes ☐ No
If married or in a relationship, please list spouse or partner's name: _____
What was the longest time you were in a relationship? _____

For females only
Are you pregnant? ☐ Yes ☐ No If Yes – how far along? _____
Are you trying to get pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No **With whom?** _____
If yes, please list:

Name	Age	Gender

Do you have any siblings? ☐ Yes ☐ No **Are you the** ☐ youngest ☐ middle ☐ oldest
If yes, please list:

Name	Age	Gender

Where (place) were you raised and by whom? _____

What is your native language? _____

Are your parents still alive? ☐ Yes ☐ No

How would you describe your relationship with your parents / siblings / partner? _____

Part 3. Education & Work History

Educational Level completed? _____

Name of school: _____

What is your current Occupation? _____ **Length of employment:** _____

If unemployed, what was your previous occupation and since when unemployed? _____

Part 4. Medical Information

Primary Care Practitioner: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Do you receive ongoing health care from any other practitioners? (*e.g. massage therapy, acupuncture*, reflexology)
☐ Yes ☐ No If yes, please describe:

Do you have any pre-existing medical conditions / concerns? *(e.g. asthma, diabetes, High Blood Pressure)*

Asthma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No

Any seizure disorder other than epilepsy? ☐ Yes ☐ No

Other medical conditions - Please list – use back side or last page if needed:

Do you have any past traumas, medical hospitalizations, surgeries, serious illness, childhood illness … etc
(include accidents, relocations, ending of relationships, rehab, cancer etc)
Please list details & year (or age) of occurrence – use back side or last page if needed:

Part 4. Medical Information continued

Are you currently taking any medication or supplements *(incl. asthma medication, birth control / vitamings, herbal or homeopathic supplements)* ☐ Yes ☐ No If yes, please list name and reason for taking:

Do you have any allergies? ☐ Yes ☐ No If yes, please describe to what you are allergic to.

Part 5. Mental Health Information

Do you receive mental health care from any other practitioners? (*e.g. therapist, psychologist, psychiatrist*)
☐ Yes ☐ No If yes, please describe:

Do you have any pre-existing psychiatric conditions / concerns? ☐ Yes ☐ No
If yes, please describe – use back side or last page if needed:

Are you in, or did you receive any past inpatient / outpatient treatments? ☐ Yes ☐ No
Please list condition, year (or age), and facility – use back side if needed:

Are you currently taking any psychiatric medication ☐ Yes ☐ No
If yes, please list name and reason for taking:

Part 6. Family Health & Mental Health History

Family medical history (*e.g. mother: breast cancer; grandfather: high blood pressure; asthma, kidney failure etc*)
Please describe:

Family psychiatric history (*e.g. aunt: depression; grandfather – maternal: suffering from schizophrenia*)
Please describe:

Part 7. General Health and Nutrition

Do you exercise or participate in any sports? ☐ Yes ☐ No
If yes, please list type and frequency (how often per day / week / month):

Food preferences:
☐ No preference ☐ Wheat free ☐ Dairy free ☐ Vegetarian ☐ Vegan
☐ Organic ☐ High protein ☐ Macrobiotic ☐ Meat ☐ Other: _____
☐ **Coffee** / cups per day: _____ ☐ **Tea** / cups per day: _____ ☐ **Soft drinks** per day: _____
☐ **Water** / glasses per day: _____ **Daily intake of Sugar** (*e.g. in chocolate, coffee, tea):* _____

Appetite:
Do you eat regularly? ☐ Yes ☐ No How many meals per day do you eat? _____
Did you notice a change in appetite over the past 3 month? ☐ Yes ☐ No _____
Did you experience weight gain or weight loss over the past 3 -6 month? ☐ Yes ☐ No _____

Sleep:
How many hours do you sleep? _____
Are you able to continuously sleep through the night? ☐ Yes ☐ No
If no, please explain (e.g. waking up due to nightmares, need to use the bathroom):

Do you nap during the day? ☐ Yes ☐ No ☐ Sometimes Length of nap: _____

Part 7. Social History

Do you have any friends and do you see them regularly? ☐ Yes ☐ No

How would you describe your **Alcohol consumption?**
☐ Never ☐ Rarely ☐ Moderate ☐ Daily

If Daily, **how much and what** do you consume?

Do you smoke? – Nicotine intake:
☐ Never ☐ Rarely – How many? _____ ☐ Moderate – How many? _____
☐ Daily – How many? _____ ☐ I previously quit → When: _____

Do you take any recreational drugs? ☐ Yes ☐ No
If yes, please indicate what (kind) and when last used:

Do you have any Hobbies / Interests? / Self-development pursuits ☐ Yes ☐ No
If yes, please list

Part 8. Spirituality

Do you consider yourself to be religious or spiritual? ☐ Yes ☐ No If yes, please describe your faith or belief:

Part 9. Session Focus

Please take some time to answer the following questions. These questions will help you prepare for our session together.

1. **What is the reason for your visit?**
2. **What is your primary concern?**
3. **What is your idea of the cause?**
4. **What makes it feel better?**
5. **What makes it feel worse?**
6. **What are some outcomes that you would like?**
7. **How would your life be different if you didn't have this issue?**
   a. **What might you be doing?**
8. **What is the end outcome?**

Is there anything else I should know about?

Thank You!

Thank you for completing this form to the best of your ability.
The information you provided enables me to serve your needs more effectively.

If you have any questions please ask as I am happy to help.

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