New Growth Psychotherapy llc
Joy Lanzano

Client Intake/Information

Please answer the questions below. This information is very useful in therapeutic work and is protected as confidential information. Answering these questions truthfully helps me in effectively supporting you. Please fill out this form and bring it to your first session.

Service requesting:
❑ Couples Co-Therapy ❑ Individual Therapy ❑ Family Therapy
❑Not sure

Name: Birthdate(month/day/year):

Address:

Phone number: Can we leave a message?

Email:

Note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact: Phone:

Insurance Company: Insurance ID#:
Group#:

Relationship:
❑ Single
❑ Married
❑ Domestic partner
❑ Divorced
❑ Separated
❑ Widowed/widower

Family/Children (names/ages): n/a

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current overall physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good
Please list any specific health problems that you are currently experiencing:

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2. Are you currently experiencing anxiety, panic attacks or have any phobias?
❑ No. ❑ Yes. If yes, please describe and indicate for how long:

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3. Are you currently experiencing any chronic pain? If yes, please describe and indicate for how for how long?

4. Are you currently taking any prescription medications?
❑ No.
❑ Yes.

Please list:

5. Have you ever taken any prescribed psychiatric medication? ❑ No. ❑ Yes.

Please list:

6. Are you using recreational drugs or alcohol to cope with depression or anxiety, if yes roughly how much or how often and what do you use?

7. Are you currently in a romantic or committed relationship? If yes, please describe and indicate for how long:
On a scale of 1-10 (with the 10 being worst and 1 being best) how would you rate this relationship?

8. Please list any recent significant life changes or stressful events you have experienced:

GENERAL FAMILY MEDICAL HSTORY:
In this section, identify is there is a family history of any of the following issues. This includes yourself. If yes to any. Please indicate the family member's relation to you:

	Please Circle	Who/Family Member
Alcohol Abuse	Yes/No	
Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic violence	Yes/No	_____
Eating Disorder	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Disorder	Yes/No	_____
Schizophrenia	Yes/No	_____
Bipolar	Yes/No	_____
Suicide Attempts	Yes/No	_____
Cancer	Yes/No	_____
Heart Attack	Yes/No	_____
Dementia	Yes/No	_____
Alzheimer's	Yes/No	_____
Brain Injury	Yes/No	_____

ADDITIONAL INFORMATION:

1. What do you consider your strengths? Please be specific

2. What do you consider some of your challenges? Please be specific

3. What would you like to accomplish out of your time in therapy? Please be specific.

Client signature: Date: