



5655 Lindero Canyon Rd, Suite 202, Westlake Village, CA 91362 • (415) 299-2376 • info@sherrygaba.com • sherrygaba.com

NEW CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:

(Last) (First) (Middle Initial)

Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: _____ May I leave a message? Yes No

Cell/Other Phone: _____ May I leave a message? Yes No

Please provide emergency contact information (name, address, phone number(s):

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Marital Status:

- | | | | |
|---------------|----------------------|---------|-----------|
| Never Married | Domestic Partnership | Married | Separated |
| Divorced | Widowed | | |

Please list any children/age:

Briefly, what is the main problem for which you are seeking my assistance? (i.e., depression, anxiety, relationship problems, stress, parenting difficulties, etc.):

Have you previously been in counseling before?

No Yes

If so, with whom? Was it helpful? Why or why not?

Health and Social Information:

1. How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. Are you currently taking any prescription medication?

No Yes

If yes, please list: _____

3. Have you ever been prescribed psychiatric medication?

No Yes

Please list and provide dates prescribed:

4. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

5. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

6. Please list any difficulties you experience with your appetite or eating patterns:

7. Are you currently experiencing overwhelming sadness, grief or depression?

No Yes

If yes, for approximately how long? _____

8. Are you currently experiencing anxiety, panic attacks or have any phobias?

No Yes

If yes, when did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain?

No Yes

If yes, please describe?

10. Have you ever thought about hurting yourself? No Yes

11. Have you ever tried to commit suicide? No Yes

12. Have you ever been hospitalized for psychiatric reasons? No Yes

13. Do you drink alcohol? No Yes

If yes, how much per week? _____

14. Do you engage in recreational drug use?

 Daily Weekly Monthly Infrequently Never

15. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10 (10 being the best), how would you rate your relationship? _____

16. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, mother, grandfather, aunt, etc.).

Please Check (yes or no) **List Family Member(s):**

Alcohol/Substance Abuse	no	yes	_____
Anxiety	no	yes	_____
Depression	no	yes	_____
Domestic Violence	no	yes	_____
Eating Disorders	no	yes	_____
Obesity	no	yes	_____

Obsessive Compulsive Behavior	no	yes	_____
Schizophrenia	no	yes	_____
Suicide Attempts	no	yes	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation?

2. Do you enjoy your work? Is there anything stressful about your current work?

3. What do you consider to be some of your strengths?

4. What are some effective coping strategies that have worked for you?

5. What are some of your goals for therapy?

6. Referred by (if any):
