M.A.Y. Frog Therapy
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NEW CLIENT INTAKE

Name(s): _____ **Date:** _____

Home Phone: _____ **Alternate Phone:** _____

Home Address: _____

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

Email: _____ **DOB:** _____ **Age:** _____

Gender: Female _____ Male _____ Transgender _____ Transman _____

Transwoman _____ Gender Nonconforming _____ Other _____

Orientation: Straight _____ Gay _____ Lesbian _____ Bisexual _____

Asexual _____ Queer _____ Questioning _____ Other _____

Prefer not to answer _____

Partner/Spouse: _____ **Cellular Phone:** _____

Email: _____ **DOB:** _____ **Age:** _____

Contact in an Emergency Situation: _____

Telephone Number: _____ **Relationship:** _____

What concern/s brings you to counseling? _____

Describe current concerns, issues, or problems that you hope to resolve: _____

_____

What do you hope to gain from therapy? _____

How did you find me? _____

(Psychology Today, Theravive, Google Search, Yelp, Referral, etc.)

To be completed if Client is a Minor:

Parent/Guardian: _____

Contact Information: _____

If parents are divorced, who has legal custody? _____

Relationship Status (Please check all that apply)

Are you presently married or involved in a relationship? Yes _____ No _____

If you answered yes, how would you describe your current level of satisfaction with the relationship

_____

Have you been married previously? _____ If yes, when? _____

Rate your level of contentment/happiness/satisfaction on a scale of 1 to 10 (1 indicating being extremely unhappy, and 10 indicating being extremely happy) _____

Rate your level of commitment to your relationship on a scale of 1 to 10 (1 indicating not feeling committed or 10 indicating a sense of deep commitment) _____

Employment Status (Please check all that apply)

Working Full-Time _____ Working Part-Time _____ Retired _____

Unemployed and looking for work _____ Not employed due to other reasons _____

Full-Time Student _____ Part-Time Student _____ On Medical Leave _____

Education (Please check the *highest* level of education/degree you have received)

Elementary (Grades 1-8) _____ High School (no diploma) _____ High School Diploma/GED _____

Some College (no degree) _____ Technical/Trade School Graduate _____ Associate's Degree _____

Bachelor's Degree _____ Master's Degree _____ Doctoral Degree _____

Military History

Current Active Duty _____ Length of Service _____ Never Served in the Military _____

If you have served/are serving, have you been deployed? _____ Where & When?

_____

Legal History

Have you been court ordered to participate in therapy? _____

Are you currently involved in any kind of litigation or legal dispute? _____

MEDICAL HISTORY

Are you currently under a medical physician's care? YES / NO

If yes, please describe current medical condition/s: _____

_____

Medications currently used: circle if NONE

Medication	Dosage	Dr. Prescribing	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling or Chemical Dependency Treatment/Services: circle if NONE

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____

ALCOHOL/SUBSTANCE USE HISTORY

Is there family Alcohol/Substance Use History: _____ If yes, with whom and for what substance

_____

Please indicate your substance use status: _____

Type(s) of substances currently using: circle if NONE

Substance	Frequency	Length of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have an alcohol/substance abuse history, please indicate the types of treatment you have received, and effectiveness of the method _____

_____

Have you ever experienced as a result of substance use: Overdose _____ Depression _____

Suicidal Impulses _____ Anxiety _____ Blackouts _____ Loss of control _____ Other _____

Do family members/friends ever complain about your substance use behaviors? Yes No

Have you lost friends or alienated family members due to your substance use behaviors? Yes No

Have you ever been reprimanded at work due to your substance use behavior? Yes No

Do you ever take prescription medication in a way that is not advised (more than prescribed or more than advised)? Yes No

MENTAL HEALTH QUESTIONS

Do you currently feel suicidal (i.e. have thoughts of harming yourself in any way)? Yes No

If yes, how long have you had these thoughts: _____

If yes, how frequently have you had these thoughts: _____

Have you ever attempted suicide or to seriously harm yourself? Yes No

If yes, please describe when and the situation: _____

_____

Do you currently have the intent to harm, seriously hurt, or kill another individual? Yes No

If yes, how long have you had these thoughts: _____

If yes, how frequently have you had these thoughts: _____

Have you been physically, emotionally, or verbally abused in your life? Yes No

If so, with whom and when? _____

Do you feel safe in your current relationship? Yes No

If no, please explain: _____

Have you ever been sexually abused? Yes No

If yes, please explain: _____