

# NEW CLIENT INTAKE FORM

**Carol Ambrose, LCPC**

**10 North Jefferson Street #401 Frederick, Maryland  
21701 17 East High Street Hancock, Maryland 21750**

**And**

**2311 Papermill Road Winchester, Virginia 22601**

New Clients Only: Please complete and bring to first session.

## PERSONAL INFORMATION

Client Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth date(s) \_\_\_\_\_ Age(s) \_\_\_\_\_

Street Address \_\_\_\_\_

Phones: H \_\_\_\_\_ C \_\_\_\_\_ Best times to call \_\_\_\_\_

Email Address (optional) \_\_\_\_\_ (This will not be

shared). Marital Status: Single \_\_\_ Engaged \_\_\_ Married \_\_\_ (When?) \_\_\_\_\_

Widowed \_\_\_ (When?) \_\_\_\_\_ Divorced \_\_\_ (When?) \_\_\_\_\_

Education \_\_\_\_\_ Occupation \_\_\_\_\_

Currently Employed? \_\_\_\_\_

Religious Affiliation? \_\_\_\_\_

Prior Counseling? Yes \_\_\_ No \_\_\_

Household Members—include age and relationship:

Emergency Contact (name, relationship, address, phone numbers including cell):

Nature of the problem to be addressed in counseling;

Most difficult relationship right now:

CRISIS INFO: Any past or present suicidal thoughts, feelings, or actions? If so, please explain:

Any current violent (including homicidal) thoughts or feelings? Anger control problems?

Is there a threat to you of significant harm or loss? Explain.

**MEDICAL INFO:**

Your primary physician' s name, address, phone

List medical conditions:

List all medications you are taking:

Have you ever been hospitalized for mental health reasons?

If so, diagnosis?

Anything else important for your therapist to know?

Signature\_\_\_\_\_

Date\_\_\_\_\_