Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

Form 5. Client Contact and Intake Form- Adult

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexuality: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s): _____
Is it ok to leave a voicemail? YES NO

Email: _____
Would you like to receive email communication? YES NO

Is it ok to send something in the mail? YES NO

How were you introduced to us? _____

** Please complete below for additional client*

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexuality: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s): _____
Is it ok to leave a voicemail? YES NO

Email: _____
Would you like to receive email communication? YES NO

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

General Intake Questions

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance.

1. _____
2. _____
3. _____

What do you think those that care about you would say their concern(s) is/are regarding you?

_____
_____
_____

What solutions (helpful or unhelpful) have you tried to resolve your concerns?

_____
_____
_____

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful? unhelpful?

_____
_____
_____

What are your expectations from therapy? What are your expectations of the therapist?

_____
_____

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you would like to occur.

_____
_____

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

_____
_____

Do you foresee any obstacles to achieving your goals or the desired changes?

_____
_____

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

How long do you think therapy will need to last to achieve your goals? Write down a target date.

_____

List 5 strengths about yourself or that others say about you, give examples of each:

1. _____
2. _____
3. _____
4. _____
5. _____

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

_____

Medical & Wellness Information

What do you do for wellness?

_____

_____

Have you ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, medications prescribed and results.

_____

_____

Do you have any allergies? (Food, environment, medicinal, animal etc.)

_____

Do you have any current or past medical issues, hospitalizations, accidents, injuries, or surgeries? If yes, please list.

_____

_____

_____

Is there a family history of the above medical issues/concerns?

_____

_____

Are you presently under a physician's/psychiatrist's care? If so, for what reason? Name and telephone of doctor.

_____

_____

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

_____

_____

In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

_____

_____

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons.

_____

_____

Important Questions

Have you ever had suicidal ideation? YES NO
If yes, please explain:

_____

_____

Have you ever formed a suicidal plan? YES NO
If yes, please explain:

_____

_____

Have you ever attempted suicide? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Have you ever felt you wanted to seriously harm or kill someone else? YES NO
If yes, please explain:

_____

_____

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

Is there any history or presence of abuse or violence? YES NO
If so, please explain.

Are you currently using any illegal drugs or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain.

Do you have any current legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

What is your highest level of education completed, name of school, and field of study?

What do you enjoy doing during your free/leisure time?

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

Intimate Relationships

If you are currently in a relationship, describe your relationship.

_____

_____

How would you describe your communication?

_____

_____

* If you are in a relationship answer the following regarding your relationship:

1. Like _____
2. Dislike _____
3. Not enough of _____
4. Too much of _____
5. Ideal relationship _____

Understanding Your Family & Influences

** Space left for therapist to draw family tree (genogram)*

Parent's Marital Status

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

_____

_____

How would you describe your upbringing?

_____

_____

Who lives with you currently?

_____

_____

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

Form 5. Revised 03/2022

Describe your relationship with the following.
Mother.

_____

Father.

_____

Mother's Significant Other.

_____

Father's Significant Other:

_____

Siblings: Age, Name and Sex.
Sibling 1

_____

Sibling 2

_____

Sibling 3

_____

Sibling 4

_____

Children:
Child 1

_____

Child 2

_____

Child 3

_____

Child 4

_____

Significant Other/Spouse.

_____

Relationships

Describe your relationship with your friends.

_____

_____

Who would you say your support system is (people, organizations, or affiliations)?

_____

Do you belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____

Phillips Mental Health Counseling PC
61-18 190th Street suite 236
Fresh Meadows, NY 11365
Website: www.phillipsMentalHealthCounselingPC.com
Email: Lynda@PhillipsCounselingPC.com
Tel: 917-692-1459

How do your religious or spiritual beliefs/practices influence your life?

_____

_____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results.

_____

_____

_____

_____

Please answer the following questions

Primary care Physician

Name:

Tel:

Address:

List any Previous or Current Medications if any:

_____

_____

End of document.
Revised 03/2022.