NewVu THERAPY
7777 Glades Road Suite 205
Boca Raton, FL 33434
(561) 613-5217

CLIENT INTAKE – ADULT

1. Identifying Information

Name:_____ Date of Birth:____/____/____

Age:_____ Sex: _____ Phone: _____

Are you: __Single __In a Relationship __Cohabitating __Married __Separated __Divorced

How were you referred to NewVu? _____

Emergency Contact (Name, Relationship, Phone): _____

Address: _____

Who lives in your household? _____

Highest level of education: _____Occupation: _____

How satisfied are you with your work? _____

Were you adopted? _____ **Parents** __ together __ separated __ divorced __ deceased __ other

Siblings Name: _____ Age: _____ Sex: _____ Location: _____

Name: _____ Age: _____ Sex: _____ Location: _____

Name: _____ Age: _____ Sex: _____ Location: _____

Children Name: _____ Age: _____ Sex: _____ Grade: _____

Name: _____ Age: _____ Sex: _____ Grade: _____

Name: _____ Age: _____ Sex: _____ Grade: _____

2. Medical History

Doctor's Name: _____Phone/City: _____

Allergies: _____Date of last physical: _____

Current medications: _____

Major operations, illness, accidents:_____

_____

Have you every experienced a head injury? _____ Lost consciousness? _____

3. General Health

Nutrition

Current Supplements/Vitamins: _____Dietary Restrictions: _____

What are the main components of your typical diet?

Breakfast:_____Lunch: _____

Snacks: _____Dinner: _____

Sleep

Do you experience any of the following?

NewVu THERAPY
7777 Glades Road Suite 205
Boca Raton, FL 33434
(561) 613-5217

__ Difficulty falling asleep __ Restlessness during sleep __ Waking up throughout the night

__Waking up early __ Difficulty waking up __ Feeling unrested after sleep

__ Decreased need for sleep __ Increased need for sleep __ Tired/exhausted most of the time

Current sleeping arrangements: _____

Exercise

What is your ideal exercise/workout regimen? _____

How often are you able to adhere to this? _____

What gets in your way of exercising regularly? _____

4. Family History

In your family, is there, or has there ever been, any of the conditions listed on the following checklist?

CONDITION	RELATIONSHIP TO YOU	PATERNAL OR MATERNAL?
Psychiatric Issues (i.e. Bipolar, Schizophrenia)		
Depression or Anxiety		
ADD/ADHD		
Learning Disabilities		
Alcohol or Drug Issues		
Legal Issues or Arrests		

5. Developmental and Childhood History

Were you a planned child? _____ Age of Mother at birth: _____Father: _____

Were you exposed to any drugs or alcohol in utero? _____Premature? _____ Breast-fed? _____

Did your mother experience any post-partum issues, depression, anxiety? _____

How were your grades? _____ IEP/Special programs? _____

How did you feel about school and your teachers? _____

How did your parents discipline you? _____

6. Substance Use and Legal History

Have you ever been arrested? If so, what were the charges and outcome? _____

Are you currently having problems with alcohol or substances? _____

Have you had any past difficulties with alcohol or substances? _____

7. Social History

How many significant relationships have you had? _____ Why did they end? _____

_____

Do you have close friend(s)?_____

What are your interests and hobbies? How do you spend your free time?_____

_____

NewVu THERAPY
7777 Glades Road Suite 205
Boca Raton, FL 33434
(561) 613-5217

Mark which of the following you have experienced at any time in your life:

__Conflict between your parents
__Serious illness of a loved one
__Physical abuse
__Sexual abuse (molestation, rape, etc.)
__Relocation
__Custody issues between your parents
__Law enforcement called to the home
__Emotional abuse (name calling, excessive criticism, etc.)
__Exposure to violence
__Loss of job

8. History of Difficulty

Small spaces have been provided. Feel free to use the back of each page for additional space and write "over" next to the question.

What prompted you to seek help now? Describe your present difficulties and their duration. What have you tried to address your current difficulties? How much have these efforts helped?

Tell me about any recent stresses, changes, or crises in your life and when they occurred. (i.e. working longer hours, family conflict, relocation, death/loss, relationship ended)

10. Emotional & Behavioral Health

Have you ever seen a mental health therapist, psychologist, or psychiatrist? _____

If so, what for? Were you diagnosed? _____

Were you prescribed medications? If so, list them. _____

What worked and/or did not work? _____

What did you like about the experience?_____ Dislike? _____

What was the outcome? _____

Please check any of the following that apply to you over the past six months:

_____ Anxious	_____ Tearful/Sad	_____ Fearful	_____ Temper/Anger
_____ Impulsive	_____ Withdrawn	_____ Isolating	_____ Difficulty Focusing
_____ Compulsions	_____ Irritable/Moody	_____ Nightmares	_____ Constipation
_____ Diarrhea	_____ Heartburn	_____ Headaches	_____ Appetite Change

Circle one:

Have you ever attempted suicide?	YES	NO	Have you recently had suicidal thoughts?	YES	NO
Have you ever harmed yourself?	YES	NO	Have you ever been psychiatrically hospitalized?	YES	NO
Have you ever harmed someone?	YES	NO	Do you have thoughts of harming someone?	YES	NO

How do you manage and respond to stress? _____

How do you manage and express anger? _____

Please add any other information that you believe is important on the back of this page.