BIRCH TREE
THERAPEUTIC ARTS

NEW CLIENT INTAKE FORM

Name _____Date of Birth _____

Address _____ City_____State_____ Zip_____

Primary Phone: _____ Primary Email: _____

May we leave voicemails/texts on you preferred Contact? (circle): call voicemail text email

Occupation:_____

Relationship Status:_____

Who do you live with?_____

How did you hear about Birch Tree Therapeutic Arts?

_____

Emergency Contact's Name & Telephone Number: _____

_____

(Release of information must be signed for emergency contact; this will be used in emergency situations only unless otherwise specified.

NEW CLIENT INTAKE FORM

Name _____
Date _____

Briefly describe your reason for seeking help:

_____
_____
_____
_____

If today was your last day of therapy, how might your life seem different?

_____
_____

Last Physician Visit : _____ List any major health problems for which you currently receive treatment:

_____

List all medications you are now taking:_____
_____

Have you received psychiatric treatment or counseling before? Yes/No
If yes, please give name(s) of provider(s), location(s) and approximate treatment dates:

_____
_ _____

Describe any family history of substance abuse or mental health problems:

_____
_____

Describe the things you currently do to help you when you are having emotional difficulties:

_____

NEW CLIENT INTAKE FORM

Name _____

Date _____

Please check all that apply to you:

Emotional

- ❏ Nervousness
- ❏ Depression
- ❏ Loss/Grief
- ❏ Sleep Problems
- ❏ Anxiety/Panic
- ❏ Mixed mood
- ❏ Loneliness
- ❏ Anger
- ❏ Low Self Worth
- ❏ Other: _____

Addictive/Compulsive Behaviors

- ❏ Alcohol Use
- ❏ Drug Use
- ❏ Spending/Gambling behaviors
- ❏ Self Harm
- ❏ Other: _____

Relationship and Family Problems

- ❏ Abuse
- ❏ Substance Abuse
- ❏ Divorce/Separation
- ❏ Abuse
- ❏ Compatibility
- ❏ Parenting Concerns
- ❏ Child Defiance/Behavioral
- ❏ School Resistance
- ❏ Other: _____

Financial/Work Problems

- ❏ Housing
- ❏ Financial Hardship
- ❏ Problems at Work/School
- ❏ Other: _____

Faith Concerns

- ❏ Briefly Explain:

_____

_____

Food/Disordered Eating Concerns

- ❏ Briefly Explain:

_____

Health and Other Concerns

- ❏ Most Recent Physician Visit_____
- ❏ Recent Change in Weight
- ❏ Postpartum Concerns
- ❏ Trouble Concentrating
- ❏ Suicidal Thoughts
- ❏ Headaches
- ❏ Chronic Pain

Sexual Concerns

- ❏ Compulsive Behavior
- ❏ Change in Sex Drive
- ❏ Anxiety/Fears
- ❏ Other _____

Other Concerns not listed:

_____

_____