LAUREN B. YERKES, PSY.D., LLC
Licensed Clinical Psychologist
PY 8432

New Client Intake Form

Contact Information

Name: _____ Nickname: _____
Address: _____
_____
Telephone Number: _____ Okay to leave messages? ☐ Yes ☐ No Okay to text? ☐ Yes ☐ No
Secondary Number: _____ Okay to leave messages? ☐ Yes ☐ No Okay to text? ☐ Yes ☐ No

E-mail Address: _____ Okay to receive e-mail? ☐ Yes ☐ No

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____
Telephone Number: _____ Secondary Phone: _____
Address: _____
_____

Demographic Information:

Date of Birth: _____ Age: _____
Sex: ☐ Male ☐ Female
Sexual Orientation: _____
Race/Ethnicity: _____
Religious or Spiritual Affiliation: _____

Employment

Employer: _____ Position/Title: _____
Length of time in this position: _____ Job Satisfaction: ☐ Low ☐ Medium ☐ High

Education

Are you currently attending school? ☐ Yes ☐ No
If yes, where? _____

Please check any of the following you have completed and provide corresponding information.

☐ High School Graduate	Or ☐ GED?	Year: _____	
☐ Associate's Degree	School: _____	Year: _____	Major: _____
☐ Undergraduate Degree	School: _____	Year: _____	Major: _____
☐ Graduate Degree	School: _____	Year: _____	Major: _____
☐ Other	School: _____	Year: _____	Major: _____

Military Service

Have you ever served in the military? ☐ Yes ☐ No
Branch: _____ Rank: _____
Year Joined: _____ Year Discharged: _____ Type of Discharge: _____
Were you in combat? ☐ Yes ☐ No

3086 Third Street South • Jacksonville Beach, FL 32250
Phone: 904.834.0584 • Fax: 904.372.0043 • E-mail: Dr.LaurenYerkes@gmail.com

Legal

Have you ever been arrested or convicted of a misdemeanor or felony? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____
_____

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____
_____

Substance Use History

Substance Type	Current Use (Last 12 Months)				Past Use				
	Y	N	Frequency	Amount	Y	N	Frequency	Amount	Year
Tobacco									
Caffeine									
Alcohol									
Marijuana									
Cocaine									
Crack									
Ecstasy/Molly									
Heroin									
Inhalants									
Methamphetamine									
LSD									
Mushrooms									
Steroids									
Bath Salts									
K2/Spice									
Prescription Medications (for recreational use) Please List:									
Other:									

Have you ever experienced withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No
If yes, please describe: _____
_____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? ☐ Yes ☐ No
If yes, please describe: _____
_____

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Medical Information

Primary Care Provider: _____ Date of last physical exam: _____
Please list any significant health concerns or diagnoses:

_____
_____
_____

Current Prescribed Medications ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, supplements, herbal remedies, etc.): _____
_____

Previous Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If yes, please complete the following:

Dates	Provider/Program/Hospital	Reason for Treatment

Have you sought outpatient counseling and/or psychiatric care (medication) in the past? ☐ Yes ☐ No
If yes, please complete the following:

Dates	Provider	Reason for Treatment

Have you ever received treatment for alcohol or substance abuse/dependence? ☐ Yes ☐ No

Family Psychiatric History

Has anyone in your biological family or extended family been diagnosed with a psychiatric disorder or had a substance/alcohol use problem? ☐ Yes ☐ No
If yes, please complete the following:

Family Member	Diagnoses or Substance/Alcohol Use Disorder

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Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Step or Half Siblings			
Spouse/Partner			
Children			
Stepchildren			
Ex-Spouses			
Other			

☐ Adopted
☐ Parents never married
☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents Divorced or permanently separated: Year: _____
    ☐ Mother remarried
        When and to whom: _____
    ☐ Father remarried
        When and to whom: _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse	☐ Neglect	☐ Lived in a foster home
☐ Sexual abuse	☐ Violence in the home	☐ Multiple family moves
☐ Physical abuse	☐ Crime victim	☐ Homelessness
☐ Parent substance abuse	☐ Parent Illness	☐ Loss of a loved one
☐ Teen pregnancy	☐ Placed a child for adoption	☐ Sexual Assault
☐ Bullying	☐ Major accident	☐ Other: _____

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Social/Interpersonal History

With whom do you live? _____
Please list those you consider to be in your support system and how they best support you: _____
_____
_____
_____
_____
_____

Do you have difficulty making and/or keeping friends? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

What are your strengths? _____
_____
_____

Any special interests, hobbies, etc? _____
_____
_____

What coping skills have helped you in the past? _____
_____
_____

Presenting Problems and Concerns

Please briefly describe your reasons for seeking treatment at this time:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ Self-esteem	☐ Relationships	☐ Hygiene
☐ Work	☐ School	☐ Housing	☐ Legal Matters
☐ Finances	☐ Sexual Activity	☐ Health	☐ Recreational Activities

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Please check all of the behaviors and symptoms you are currently experiencing as problematic:

- ☐ Sadness
- ☐ Depressed mood
- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Guilt
- ☐ Shame
- ☐ Changes in appetite
- ☐ Changes in sleep
- ☐ Loss of pleasure
- ☐ Loneliness
- ☐ Isolation/social withdrawal
- ☐ Thoughts of suicide
- ☐ Difficulty concentrating
- ☐ Distractibility
- ☐ Boredom
- ☐ Lack of motivation
- ☐ Racing thoughts
- ☐ Obsessive thoughts
- ☐ Anxiety/worry
- ☐ Compulsive behavior
- ☐ Specific fear/phobia
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Frequent crying spells
- ☐ Fatigue
- ☐ Social anxiety
- ☐ Irritability
- ☐ Anger
- ☐ Aggressiveness
- ☐ Frequent arguments
- ☐ Thoughts of harming others
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Recurring disturbing memories
- ☐ Paranoia
- ☐ Excessive energy
- ☐ Decreased need for sleep
- ☐ Impulsivity
- ☐ Wide mood swings
- ☐ Sleep difficulties
- ☐ Restrictive eating
- ☐ Binge eating
- ☐ Purging
- ☐ Poor body image
- ☐ Memory loss
- ☐ Hair pulling
- ☐ Compulsive skin picking
- ☐ Self-harm behaviors
- ☐ Hallucinations
- ☐ Gambling problems
- ☐ Problems with pornography
- ☐ Sexual problems
- ☐ Identity concerns
- ☐ Relationship problems
- ☐ Sexual problems
- ☐ Work/school problems
- ☐ Alcohol/Substance Use
- ☐ Difficulty relating to others
- ☐ Discrimination
- ☐ Divorce
- ☐ Grief
- ☐ Loss
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Have you ever made a suicide attempt? ☐ Yes ☐ No
If yes, please provide dates and details: _____
_____
_____
_____
_____
_____

What are your goals for counseling?
_____
_____
_____
_____
_____

Is there anything else you think I should know in order to provide the best treatment for you?
_____
_____
_____
_____
_____

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