



## New Client Intake Packet

### Demographic Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Birthplace: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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? \_\_\_\_\_

If you found us online what words did you search to find us?  
\_\_\_\_\_

### Emergency Contact

It is necessary that **your clinician at Pathways of Florida, LLC** has someone to contact on your behalf. In case of an emergency whom should we contact?

Full Name	Relationship	Phone Number
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By completing this part, I agree to allow Pathways of Florida, LLC to contact my emergency contact on my behalf in the case of an emergency



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### How Have We Come to Meet?

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 in regards to you?

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

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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?

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### Change is Coming...

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

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Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you will see:

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

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

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

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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?

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### Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples of each:

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How do you achieve balance in your life?

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

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Do you have any allergies (food, environmental, medicinal, animal, etc.)

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

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

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Are you presently under a physician's/psychiatrist's care? If so, for what reason?

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

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

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

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Do you drink alcoholic beverages (beer, wine, distilled spirits, and/or other)?      YES      NO

If yes, how often do you drink?      Daily      Weekly      1-2 times a month      Less frequently

How much will you usually drink in one sitting?

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When is the last time you drank any alcohol?

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Have you ever tried controlled substances (marijuana, marijuana concentrates, nicotine, cocaine, opiates, heroin, amphetamines, benzodiazepines, CBD, Kratom)?      YES      NO

Do you currently use any controlled substances?      YES      NO

If yes, how often do you use?      Daily      Weekly      1-2 times a month      Less frequently

When is the last time you used a substance?

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Do you think your alcohol or drug use is a problem?

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Have you ever had any consequences as a result of your drinking or substance use (legal, social, physical, work and/or family related, etc.)?

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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?

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### Important Questions We Must Ask

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

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Have you ever planned to hurt yourself? YES NO  
If yes, please explain:

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Have you ever attempted to hurt yourself? YES NO  
If yes, please explain:

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

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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?

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Is there any history past or present of abuse or violence? YES NO  
If so, please explain:

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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?

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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:

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

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### **Career/Job, Recreation and Leisure**

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

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

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

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### Intimate Relationships

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

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How would you describe your communication?

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How would you describe intimacy in your relationship?

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\* 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

Parent's marital status: \_\_\_\_\_

Please describe your relationship with your parents:

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How would you describe your upbringing?

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Who lives with you currently?

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Do you have any pets? If yes, names, types and relationship to each pet:

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Describe your relationship with the following:

Mother:

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Father:

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Mother's Significant Other:

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Father's Significant Other:

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Siblings: Age, Name and Sex:

a. Sibling 1

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b. Sibling 2

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c. Sibling 3

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Children:

a. Child 1

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b. Child 2

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c. Child 3

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## Relationships

Describe your relationship with your friends:

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

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Do you belong to any religious or spiritual groups?

YES

NO

If yes, what is your level of involvement?

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—Helping Others Live LIFE INSPIRED—

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

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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:

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