Evolve Internal Wellness & Counseling, LLC
Jessica C. Carreiro, LICSW

NEW CLIENT INTAKE

IDENTIFYING INFORMATION Today's Date:_____

Client's Name: _____

Partner's Name *if applicable*: _____

Address: _____ Apt#_____ City _____ State _____ Zip_____

Phone: (H) _____ (Cell) _____ (W)_____ Email _____
Message OK? ☐ Yes ☐No ☐Yes ☐No ☐Yes ☐ No

What is your preferred method of communication: ☐ Text ☐ Home Phone ☐ Cell ☐ Work Phone ☐ Email

Client's Date of Birth:_____ Age:_____ Gender Identity:_____

Preferred Pronoun: _____ Spirituality/Religion: _____

Relationship Status: _____ Sexuality Identity:_____

Ethnic Identity: _____ Other Social/Cultural/Racial Identities:_____

Educational Background (School and Degree): _____

Are you currently a student? ☐ Yes ☐ No If yes, where/for what: _____

Are you currently employed? ☐ Yes ☐ No

If employed, what is your occupation: _____ Years at current job: _____

Employer: _____

Children/Age(s): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Name of your primary medical provider: _____ Phone: _____

Date of last exam with primary medical provider: _____

Who referred you? _____

INSURANCE INFORMATION ☐ Self Pay (skip to next section if you check this box)

Name of Primary Insurance Carrier_____

Phone No. for Mental Health Benefits: _____

Insurance Identification Number: _____ Group Identification Number: _____

Policyholder's Name (if different from Client): _____ DOB: _____

Relationship of Client to Policyholder: _____ Policyholder's Employer:_____

Client Name:

PSYCHIATRIC HISTORY

Have you ever had an inpatient, partial hospitalization/day treatment and/or intensive outpatient treatment? If yes, please elaborate:

_____
_____
_____

Have you ever taken or are you currently on psychotropic medication? If yes, please include prescriber, names of meds and doses:

_____
_____
_____

Have you ever been in talk therapy/psychotherapy before? If yes, please provide dates and name(s) or providers: _____
_____
_____
_____

FAMILY HISTORY

	Name	**Age/ Year Passed**	**Occupation/Education**	**Psychiatric History?**
Mother				
Father				
Spouse/Partner/ Significant Other				
Sister(s)				
Brother(s)				
Children				
Other (e.g., step-parent, significant grandparent)				

Client Name:

SOCIAL HISTORY

Did you ever or are you currently serving in the military? □ Yes □ No If yes, which branch? _____

For how long _____

If yes, did you ever deploy? □ Yes □ No If yes, where and when _____

Is anyone currently harming you financially, verbally, physically, emotionally or sexually? □ Yes □ No (circle which)

Has anyone ever harmed you in these ways? □ Yes □ No

Please elaborate_____

_____

_____

_____

MEDICAL HISTORY *(Significant past or current physical illness, injuries, hospitalizations, medications. Please include dates.)*

_____

_____

SUBSTANCE USE *(Please describe any past or current use of alcohol and/or drugs including any recent increase or decrease in use and why.)*

_____

_____

_____

_____

PRESENTING CONCERNS & GOALS *(Main areas that you would like to address in therapy)*

_____

_____

_____

_____