



Anjana Freeman, MS LPC

Mental Health Consultant and Therapist

New Client Intake Form

File # _____

Full Name: _____ Preferred Name: _____ Date of Birth: _____

Parent/Guardian for Minors: _____ Relationship: _____

Age: _____ Address: _____

County of Residence: _____ County of Incident: _____

Phone #: _____ Email: _____

Is it safe to contact you at the number above? _____

Is it safe to leave scheduling information on the email you provided? _____

Emergency Contact and Phone number

What other method of communication do you prefer? _____

How did you hear about Rape Response, Inc? _____

Briefly, describe what you want me to know about you and your situation.



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Please mark yes to symptoms that match your experience	Yes	Please mark yes to symptoms that match your experience	Yes
Feelings of guilt		Separation/divorce	
Feeling disoriented to time or place		Death of a loved one/loss/grief	
Paranoia		Being verbally abusive to others	
Disorganized thinking		Being verbally abused	
Suicidal thoughts		Being physically abusive to others	
Self-harming urges		Being physically abused	
Low self-esteem		Being sexually abusive to others	
Obsessing over things		Being sexually abused	
Thought disturbances		Legal problems	
Racing thoughts		Career problems	
Difficulty concentrating		Gambling	
Self-distaining thoughts		Substance use/abuse/addiction	
Overeating		Relationship problems	
Binging/purging		Poor boundaries	
Loss of appetite		Aggressive behaviors	
Traumatic flashbacks		Isolating behaviors	
Difficulty sleeping		Difficulty having sexual relations	
Nightmares/strange dreams		Passive behaviors/fear of speaking up	
Decline of motivation		Seeking approval	
Fatigue		Violent thoughts or outbursts	
Memory loss		Stealing/Lying/Cheating	
Crying spells		Impulsive behaviors	
Depression		Financial problems	
Anxiety/worry		Homicidal thoughts	
Envy/jealousy		Dissociating	
Shame		Spiritual/religious problems	
Anger/hostility		Hair pulling	
Loneliness		Fear of rejection	

What experiences or symptoms seem the most urgent to discuss in therapy?



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Have you been in therapy before? **	Yes	No
If yes, please describe: _____		
Do you have any medical problems? **	Yes	No
If yes, please describe: _____		
Are you currently prescribed medication? **	Yes	No
If yes, please describe: _____		
Do you have a known mental illness? **	Yes	No
If yes, please list: _____		
Do you experience thoughts of hurting yourself?	Yes	No
Are you committed to treatment?	Yes	No
<p>**If you are prescribed medication or seeking therapy from another provider, it may be helpful to give me permission to communicate with that provider. If you consent to communication between me and another healthcare provider, please complete the HIPAA Privacy Authorization Form.</p>		

I have read and understand the Consent to Counseling form as well as all other documents provided to me. I have given truthful information to the best of my ability on all forms provided to me.

Client Signature _____

Date _____



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Demographics

Race (select all that apply) Native American/ Alaskan Asian Black/African American Caucasian Native Hawaiian/Pacific Islander Declined	Hispanic Ethnicity (select all that apply) Cuban Mexican Puerto Rican Other Hispanic Declined Not Applicable	Gender identity Female Male																				
Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Married, separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Sexual Orientation <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> Declined																					
Living Arrangement (select all that apply) <input type="checkbox"/> Alone <input type="checkbox"/> With Partner/significant other <input type="checkbox"/> With Spouse <input type="checkbox"/> With Children	<input type="checkbox"/> With Mother <input type="checkbox"/> With Father <input type="checkbox"/> With Sibling(s) <input type="checkbox"/> With relatives <input type="checkbox"/> With unrelated people																					
Family Members in Home: <table border="1"> <thead> <tr> <th><i>Name(s)</i></th> <th><i>DOB or Age</i></th> <th><i>M or F</i></th> <th><i>Relationship to Client</i></th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>			<i>Name(s)</i>	<i>DOB or Age</i>	<i>M or F</i>	<i>Relationship to Client</i>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Current Primary Role <input type="checkbox"/> Employed (Full time 35+ hours/week) <input type="checkbox"/> Employed (Part time 35 or less hours/week) <input type="checkbox"/> Unemployed	Highest Education Level Completed: <input type="checkbox"/> Below 9th grade: <input type="checkbox"/> Between 9th and 11th grade: _____ <input type="checkbox"/> 12th grade or GED <input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree	Previous or Current Services (check all that apply): <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Adult Corrections <input type="checkbox"/> Developmental Disabilities and/or Special Education <input type="checkbox"/> Child Welfare <input type="checkbox"/> Mental Health and/or Substance Abuse Treatment																				
Are you currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what grade are you in? _____																						

