Tides of Healing
COUNSELING SERVICES
Caitlin MacCalla, M.A, LMFT

Address: 4010 Moorpark Ave. #118, San Jose, CA. 95117
Main: (650) 799-1762
Email: cmaccalla.lmft@gmail.com
Web: www.tidesofhealing.com

New Client Intake Form

Today's Date: _____

Last Name:_____ First:_____Middle Initial: _____

Age:_____Date of Birth: _____

Address: _____
Street City Zip code

Phone Number_____(Cell/hm/wk) OK to leave message? Yes ☐ No ☐

Email: _____

Emergency Contact:_____/_____
Name / Relationship Telephone [Hm / C / Wk]

Religion/Spiritual Preference: _____

Are you employed: Yes ☐ No ☐ ☐ F/T ☐ P/T Occupation:_____How long? _____

Are you in school: Yes ☐ No ☐ ☐ F/T ☐ P/T Do you enjoy your work/school? Yes ☐ No ☐

Highest Level of Education: _____

Current Relationship Status: (circle and add date of event where applicable)

Single Married since_____1st/2nd/3rd Marriage_____Separated since _____

Dom. Partnership since_____ Widowed since_____Divorced since_____ Engaged since _____

Relationship Satisfaction (please circle) : Poor---Unsatisfactory---Satisfactory---Good---Excellent

Do you have children? Yes ☐ No ☐ How many?_____ Ages: _____ _____ _____ _____

Who lives in your home (family members or others)?

Name	Relationship to you	Age	Date of Birth	Gender

[If more room needed, please use back]

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Primary Care Physician:_____Phone:_____Date of last exam?_____

Rate your current physical health, (circle): Poor Unsatisfactory Satisfactory Good Excellent

Do you have concerns about your physical health? _____

Current Psychiatrist:_____Phone:_____Last visit? _____

Are you currently under medical or psychiatric care? ☐ Yes ☐ No If yes, please indicate with whom and the reason(s): _____

List prescribed medication(s). Use reverse of paper if necessary.

Medication	Dose	Reason for taking

Alcohol use: ☐ In recovery ☐ Non-drinker ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Alcoholic

Tobacco use: ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Cigars ☐ Chews

Street drug use: ☐ In recovery ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Addicted

List alcohol and street drugs that you currently use, or have a history of using recreationally.
*Please use the back of the sheet if you need more room.

Substance or Alcohol	How much in one sitting?	How often per day, week or month?	Current	Past

Have there been changes in your sleeping patterns in the past three months? Yes ☐ No ☐

If yes, ☐ Night time waking ☐ Sleeping too much ☐ Insomnia ☐ Other, please describe: _____

Any changes with appetite or in eating patterns recently? Yes ☐ No ☐
If yes, describe : _____

Are you experiencing sadness, grief, depression, tearfulness? Yes ☐ No ☐
If yes, describe : _____

Are you experiencing anxiety, panic, panic attacks, phobias/fears? Yes ☐ No ☐
If yes, describe : _____

Are you suffering with chronic pain? Yes ☐ No ☐ If yes, please describe :

_____

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Have you experienced abuse/trauma in your adult life, such as domestic violence, accident, rape?

Please circle all that apply:

physical emotional verbal sexual mental neglect other (explain below)

_____

Have you experienced abuse in childhood? Please circle all that apply:

physical emotional verbal sexual mental neglect abandonment bullied other

Do you currently, or have you ever physically harmed another person? Yes ☐ No ☐

If yes, please describe: _____

Are you currently involved in legal proceedings? Yes ☐ No ☐ If yes, please explain:

_____

Do you ever see or hear things other people say they can't see or hear? If yes, please explain:

_____

Have you experienced significant life changes or stressful events recently? If yes, please explain:

_____

Have you previously seen a counselor/therapist/psychologist/coach/psychiatrist? Yes ☐ No ☐

Names/Reasons/date ranges/locations: _____

_____

_____

Please circle below items if you or a family member have a current diagnosis, or a history of any of the following conditions. List family member affected, (i.e. father, mother, brother, etc.).

	Self	Family Member
Alcohol/Substance Abuse/Dependence	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorder	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Bipolar Disorder	yes/no	
Suicide Attempts	yes/no	
ADHD	yes/no	
Other	yes/no	

Other significant medical, family or psychological history you would like your therapist to know:

_____

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Have you ever attempted suicide? Yes ☐ No ☐ If yes, when? _____

Do you currently have suicidal thoughts? Yes ☐ No ☐
Suicide & Crisis Hotline: (1-855-278-4204 or 911)

Has a family member attempted suicide? Yes ☐ No ☐ If yes, who _____

when?_____Was the suicide attempt completed? Yes ☐ No ☐

Do you now, or have you ever harmed yourself, such as cutting, scratching, burning, hitting? Yes ☐ No ☐ If yes,

in what manner? _____

Have you ever been hospitalized for psychologically related reasons? Yes ☐ No ☐ If yes, please explain when/where/why:

_____

_____

Reason you are seeking counseling today, include symptoms.

_____

_____

Date symptoms first began?_____How do you hope counseling will help?

_____

What have you tried to resolve the problem up to now? What has helped? What made it worse?

_____

_____

Is there anything else you feel it is important for your therapist to know?

_____

_____

_____

_____

_____

_____

_____

_____

How to did you hear about me? (Who referred you?):

☐ Friend/relative ☐ Court/Social Services ☐ Doctor/Therapist _____

☐ Internet ☐ Other/ Specify_____

Would you like a statement to submit to your insurance company (known as a Superbill)?

Yes ☐ No ☐