Rachel Korenblit, LCSW, LLC
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PERSONAL INFORMATION/INTAKE

IDENTIFYING INFORMATION:

Client Name(s): _____

Guardian(s) / Parent(s) (if client is under 16 years of age): _____

Phone: ☐ (H) _____ ☐ (C) _____ ☐ (W) _____

☐ Email: _____

Best hours to reach you: _____ * *Check preferred method of contact*

Permanent Address: _____

Check if you are comfortable being contacted via ☐ Phone ☐ Text ☐ Email ☐ Voicemail

In case of emergency contact: _____ Relation: _____

Address: _____ Phone: _____

How did you hear about Rachel Korenblit, LCSW? _____

Date of birth of client: _____ Age: _____ Gender: _____

Occupation: _____ Marital Status: _____

PREVIOUS COUNSELING:

____ Private therapist (name: _____ dates: _____)

____ Drug/alcohol treatment (where: _____ dates: _____)

____ Other (specify: _____ dates: _____)

____ None

Reactions to previous counseling: _____

_____

HEALTH:

Client's existing medical problems or current physical symptoms: (please describe)

_____

List current medications: _____

_____

Prescriber name: _____ Number: _____

Use of:

Alcohol: _____ how often: _____
Caffeine: _____ how often: _____
Tobacco: _____ how often: _____
Other drugs: _____ how often: _____ what types: _____

PLEASE STATE BRIEFLY WHAT YOU WOULD LIKE TO DISCUSS WITH A THERAPIST: _____

_____

PLEASE CHECK ALL OF THE EXISTING SYMPTOMS OR PROBLEMS WHICH APPLY:

- ☐ sleep disturbance (specify) _____
- ☐ change in eating behavior (specify) _____
- ☐ phobias (specify fears) _____
- ☐ substance abuse(specify) _____
- ☐ chronic pain (specify) _____
- ☐ obsessive thoughts (specify) _____
- ☐ compulsive behavior (specify) _____
- ☐ learning disability (specify) _____
- ☐ parenting (specify) _____
- ☐ sexual dysfunction (specify) _____
- ☐ death of a loved one (specify) _____

☐ withdrawal
☐ sexual orientation /sexual identity
☐ guilt, remorse, shame
☐ depression
☐ sexual abuse memories
☐ suicidal thoughts
☐ uncontrolled / unprovoked crying
☐ continuous anxiety / nervousness
☐ panic attacks
☐ muscle tension
☐ divorce
☐ social anxiety
☐ stress
☐ assertiveness

☐ weight change
☐ hyperactivity
☐ uncontrolled temper outburst
☐ physical violence
☐ abusive relationship
☐ hopelessness/helplessness
☐ missing school / work
☐ irritability
☐ difficulty with decisions
☐ chronic illness
☐ headaches
☐ self-doubts / low self-esteem
☐ attention / concentration problems

☐ other (specify) _____

Signature:_____ Date:_____