

Rachel Korenblit, LCSW, LLC

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PERSONAL INFORMATION/INTAKE

IDENTIFYING INFORMATION:

Client Name(s): _____

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, LCADC? _____

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
- other (specify) _____

- 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

Signature: _____ Date: _____