New Client Form

Therapist:_____ Date _____

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: (First, Last) _____Gender: _____ Age: _____ DOB: _____

Address _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May I leave a Voice Message? ☐YES ☐NO SS# _____

Email address: _____

Emergency Contact:_____ Relationship: _____ Phone: _____

Sexual Orientation: _____ Ethnic/Cultural Background: _____ Religion: _____

Relationship Status: _____ Education (highest degree/grade/level):_____

Occupation: _____ Annual Income: _____ Employer: _____

Referred by: _____ **May I thank this referral source for directing you to this practice?** ☐Yes ☐No

Address: _____

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:

☐ Has anything happened that may have brought on/intensified the problems you are experiencing? ☐Yes ☐No

If yes, please explain: _____

☐ When (month/year) did you first begin to experience these problems? _____

☐ How much is/are the problems affecting you? ☐Mildly ☐Moderately ☐Severely

☐ In what areas do your problems impact your life? (Check all that apply)

- ☐ Lifestyle (the way you live your life)
- ☐ Activities (things you normally do or would like to do)
- ☐ Relationships (your ability to form or maintain relationships with others)
- ☐ Eating ☐ Sleeping ☐ Mood

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

☐ Have you been thinking about suicide? ☐Yes ☐No

☐ Have you been thinking about harming or killing someone else? ☐Yes ☐No

Adult Problems Checklist

Instructions: Please check all that apply to you

- ❑ Depression
- ❑ Low energy
- ❑ Low self-esteem
- ❑ Poor concentration
- ❑ Lack of interest/enjoyment in life
- ❑ Feeling hopeless
- ❑ Feeling worthless
- ❑ Feeling guilty or shameful
- ❑ Sleep changes (more/less)
- ❑ Loneliness
- ❑ Bad dreams/nightmares
- ❑ Feeling Ignored or abandoned
- ❑ Appetite changes (more/less)
- ❑ Mood swings
- ❑ Thoughts of hurting self
- ❑ Thoughts of hurting others
- ❑ Isolating from others/social withdrawal
- ❑ Feelings of sadness/loss
- ❑ Weight problems
- ❑ Stress
- ❑ Anxiety/tension/worry
- ❑ Panic attacks
- ❑ Heart racing
- ❑ Chest pain or heaviness
- ❑ Chills/hot flashes
- ❑ Tingling/numbness
- ❑ Pain
- ❑ Fear of dying
- ❑ Fear of going "crazy"
- ❑ Nausea
- ❑ Fears or phobias
- ❑ Obsessions/compulsions
- ❑ Thoughts racing
- ❑ Disorganization
- ❑ Procrastination
- ❑ Can't hold onto an idea
- ❑ Anger/frustration
- ❑ Suspiciousness or mistrustfulness
- ❑ Problems trusting others
- ❑ Easily irritated/annoyed
- ❑ Aggressiveness
- ❑ Perfectionist behavior
- ❑ Lying
- ❑ Making/keeping friends
- ❑ Arguing with others
- ❑ Performing unusual rituals or habits
- ❑ Impulsiveness
- ❑ Excessive behaviors (Examples: spending, gambling)
- ❑ Delusions/hallucinations (Thinking/believing or seeing/hearing unusual things)
- ❑ Sexual problems
- ❑ Self injurious behaviors
- ❑ Shyness
- ❑ Social skills
- ❑ Social support (family/friends)
- ❑ Stealing
- ❑ Strange, weird, or peculiar behavior
- ❑ Confusion/can't think clearly
- ❑ Feeling "not real"
- ❑ Feeling detached from yourself
- ❑ Feeling "hyper"
- ❑ Financial problems
- ❑ Grief/bereavement
- ❑ Health problems
- ❑ Impact of your problems on others
- ❑ Losing track of time
- ❑ Problems with memory
- ❑ Unpleasant thoughts that won't go away
- ❑ Bothered by recurring thoughts
- ❑ Job/career problems or indecision
- ❑ Destruction of property
- ❑ Self-criticism
- ❑ Family problems
- ❑ Marital/relationship problems
- ❑ Parent/child problems
- ❑ Use of alcohol
- ❑ Use of drugs
- ❑ Blackouts
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Partner abuse
- ❑ Trouble with the law
- ❑ Experienced/witnessed trauma
- ❑ Loss/death of someone close
- ❑ Other (please describe):

Current Life Experiences

☐ I live in: ☐Apartment ☐House ☐Condo/Townhouse ☐Mobile Home ☐Rooming House ☐Other

☐ I live with:

Name	Age	Relationship to me	Problems

☐ My sources of satisfaction:

_____

☐ My sources of stress:

_____

☐ My leisure activities:

_____

☐ My current life goals:

_____

☐ What I hope to gain from counseling/therapy:

History of Counseling or /Therapy

☐ Are you <u>currently</u> being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above? Yes No If yes, please provide the following information:

Date(s) Name of Professional Address Treatment Type (counseling, therapy, medication, etc.)

_____

_____

☐ Please provide information regarding <u>previous</u> treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s) Name of Professional Address Treatment Type Why treatment ended

_____

_____

☐ Have you ever been hospitalized for treatment of an emotional or mental disorder? ☐Yes ☐No

If yes, please provide the following information:

Date(s) Name of Hospital or Facility Address Reason for Hospitalization

_____

_____

Medical History

☐ Please complete the information below regarding <u>past and current</u> medical conditions and treatment:

Date(s) Physician Name / Address Condition Treatment Results

_____

_____

_____

☐ **Please list all <u>current</u> prescription and over the counter medication use:**

Beginning (date) Medication Dose Frequency of use Condition Treated

_____

_____

_____

_____

☐ Please list any <u>previous</u> prescription and over the counter medication use significant to your counseling/therapy:

Date(s) Medication Dose Frequency of use Condition Treated

From_____To_____

From_____To_____

From_____To_____

From_____To_____

☐ Please list any <u>current or previous</u> use of street drugs, tobacco products, or alcohol:

Date(s) Type Used Frequency of Use Amount Typically Used When ended (if applicable)

_____

_____

_____

☐ Is there anything else you think it would be important for me to know:

_____

_____

_____

_____

<u>PLEASE CAREFULLY READ THE STATEMENT BELOW:</u>

I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the fee policies, and the No Show/Cancellation Policy. I also acknowledge I have read the ***Consent for Treatment*** form and the ***Notice of Privacy Practices for Protected Health Information.*** By signing this document, I indicate that I have reviewed, understand, and agree to comply with the policies in this disclosure statement/agreement, and that I consent to treatment for myself or my child.

Name (Print) Name (Signature) Date

Name (Print) Name (Signature) Date

Name (minor)	Name (Signature)	Date