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New Client Information Form

Today's Date:_____

Your full name _____

Date of birth _____ Age _____

Address _____ Apt # _____

City _____State _____ Zip Code

_____ I may need to send postal mail to clients on occasion. If this is ok, please

initial here:_____

To (re)schedule appointments, where may I contact you?

Home/evening phone _____ Cell phone _____

May I leave you a voicemail message? ☐ Yes ☐ No

May I leave a message with someone at these numbers? ☐ Yes ☐ No

E-mail address _____

***Please note: Email correspondence is not considered a confidential medium of communication** I

may need to send e-mail to clients on occasion. If this is ok, please initial here: _____

Were you referred to my office by someone? ☐ Yes ☐ No

If "Yes", by whom?

_____ *Please complete*

the following:

Gender:

☐ Male ☐ Female ☐ Transgender ☐ Other_____

Ethnic/Racial Identity:

☐ African-American ☐ Asian/Pacific Islander ☐ Multi-racial ☐ Caucasian

☐ Latina/Latino ☐ Native American ☐ Other:_____

Relationship Status:

☐ Single ☐ Committed Relationship ☐ Married ☐ Separated/Divorced ☐

Domestic Partnership ☐ Widowed

Sexual Orientation:

☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Other ☐ Not Sure ☐
Prefer not to say

Emergency Contact Information

Name: _____

Address: _____

Phone: _____ Relationship to you:_____

Employment

☐ I am currently employed ☐ I am not currently employed

Name of current employer _____

Work phone _____

How long have you been at your current position?

_____ *Education*

What is the highest level of education you have obtained?_____ Would you like your therapist to coordinate treatment with your physician? ☐ Yes ☐ No If "Yes," list physician's name/ phone #_____ *B. Clinical Information - Overall health and mental health*

Have you ever previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No
If "Yes", by whom, when, and for what? _____

_____

Have you previously been prescribed psychiatric medications? ☐ Yes ☐ No If "Yes," most recent time/date & what were you prescribed?

_____

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No Have you ever made a suicide attempt/gesture? ☐ Yes ☐ No

If "Yes," most recent time/date?

_____

Please list current or chronic health problems:_____

_____

Please list current medications (prescribed and

OTC):_____

_____

Please briefly describe your reason(s) for coming in today:

_____
_____
_____
_____

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____
2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____ 3.

On average, how many times per week to you exercise?_____ 4.

Please list any difficulties you experience with your appetite or eating patterns.

_____ 5.

Are you currently experiencing overwhelming sadness, grief or depression?

☐ Yes ☐ No If "Yes," for how long?_____ 6.

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No If

"Yes," when did this start?_____ 7. How many

alcoholic drinks do you consume in a week?_____ Is this a concern

for you or anyone in your life?_____ 8. How often do you engage in recreational drug use? (please circle one) Daily Weekly Monthly Infrequently Never

Is this a concern for you or anyone in your life?_____ 9. Are you currently in a romantic relationship?

☐ Yes ☐ No If "Yes," for how long?_____ On a scale of 1 (low)-10 (high), how do you rate your relationship?_____

10. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please indicate if there is a history of any of the following for you or anyone in your family. If yes, please indicate the family member's relationship to you in the space provided.

ADD/ADHD ! ! ! ! yes/no _____ Alcohol/Substance Abuse! ! yes/no _____ Anxiety ! ! ! ! ! yes/no _____ Depression ! ! ! ! yes/no _____ Domestic Violence ! ! ! yes/no _____ Eating Disorders ! ! ! yes/no _____ Obesity ! ! ! ! ! yes/no _____ Obsessive Behaviors ! ! ! yes/no _____ Schizophrenia ! ! ! ! yes/no _____ Physical/Sexual Abuse ! ! yes/no _____ Suicide Attempts ! ! ! yes/no _____

ADDITIONAL INFORMATION

1. Are you currently employed? If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to spiritual or religious? If yes, please describe:

_____

_____

3. What do you consider to be your strengths?

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What are your goals for therapy?

_____

_____

_____

_____ _____ **Client's Signature Date**

Thank you for completing this form.
Data is used solely for the purpose of understanding treatment concerns and is confidential.