New Client Information Form

Please provide the following information below needed for our records. All information you provide is considered protected health information and will be held confidential as part of your medical record. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session.

_____ _____ _____
(Client Last name) (First) (initial)

Birth date: _____/ _____/ _____ Age: _____ Sex: ☐F ☐M

Marital Status: ☐Never Married ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partnership

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Cell Phone: _____ May we leave a message? ☐YES ☐No, Text? ☐YES ☐No

Alternate Phone: _____ ☐home ☐work, May we leave a message? ☐YES ☐No

Emergency contact: _____ _____ _____
(Phone) (Name) (Relationship)

Referred by: ☐Internet ☐MD ☐Psychiatrist ☐ Insurance ☐Therapist ☐Family/Friend ☐Self ☐other_____

Responsible Party: ☐Self, Other:_____ _____ _____
(Name) (Relationship) (Phone)

I plan to use my insurance: ☐No ☐Yes, Policy Holder:_____ DOB:_____

_____ _____ _____
(Primary Insurance) (Member ID) (Group number)

_____ _____ _____
(Secondary Insurance) (Member ID) (Group number)

Student status: ☐Not a student ☐Full-time ☐Part-time School/College name:_____

Employment status: ☐Full-time ☐Part-time ☐Self-employed ☐Not employed ☐Active duty military ☐Retired

Do you have an open Workman's Compensation claim? ☐Y ☐N On disability? ☐YES ☐No [temporary] [SSI] [SSD]

Employer: _____ Address:_____

Please describe the main reason that brings you to counseling at this time:

_____

_____

_____

Chief Concerns :

☐Depression / Sadness	☐Anxiety/Worry	☐Panic Attacks	☐Suicidal thoughts
☐Mood Swings	☐Fearfulness	☐Self-injurious behavior	☐Restlessness
☐Irritability or frustration	☐Difficulty concentrating	☐Anger/Temper	☐Feeling helpless
☐Alcohol or drug abuse	☐Low energy/fatigue	☐Insomnia/Sleep problems	☐Feeling hopeless
☐Phobia (specific fears)	☐Hallucinations	☐Grief	☐Feeling worthless
☐Impulsivity	☐Frustration	☐Tearfulness	☐Isolation
☐Obsessive thoughts	☐Stress	☐Relationship problems	☐Legal issues

Client Initials_____

Mental Health History

Have you ever received any psychiatric or mental health services? ☐None ☐Outpatient ☐Inpatient (hospital)
If yes, please list most recent providers with approximate time frames:

_____

_____

_____

Have you ever been prescribed medications for emotional or psychiatric reasons? ☐Yes ☐No

List current medications: _____

_____

Substance use history:

Have you ever received substance abuse treatment (alcohol or drugs)? ☐None ☐Outpatient ☐Detox ☐Residential treatment
If yes, please list:

_____

_____

Do you currently drink or use any recreational drugs? ☐Y ☐N
List any with frequency

_____

_____

Physical Health
Please list any health problems (list diagnosis): _____

_____

Family Mental Health and Substance Abuse History

Is there a family history of any mental health problems or substance abuse ? ☐Yes ☐No

Is there a history of suicidal behavior in your family? ☐Yes ☐No

	Mother	Father	Brother	Sister	Aunt	Uncle	Children	Grandmother	Grandfather
Anxiety									
Panic Attacks									
Depression									
Bipolar Disorder									
Schizophrenia									
Substance abuse									
Suicide attempts									

Client Initials_____

Social:

Are you currently in a relationship? ☐Y ☐N, Quality of relationship: ☐Excellent ☐Very good ☐Good ☐fair ☐Poor ☐ N/A

Do you have any children? ☐Y ☐N If yes please list children & ages: _____

_____

Do you have any siblings? ☐Yes ☐No If yes, please list each with ages. _____

_____

Who do you turn to for support?: (Check all that apply)

☐Partner/Spouse ☐Girlfriend/Boyfriend ☐Friends ☐Family ☐My Religion/Spirituality ☐ Peer Support Groups ☐Myself

What kinds of activities or coping strategies do you use when stressed?_____

_____

What are some of your personal strengths that will be helpful for you during your therapy? _____

_____

How I can Help:

What are your expectations from me? How can I best help you in your therapy?

_____

_____

When you complete therapy, what will have changed and/or be accomplished?

_____

_____

_____

Any additional comments you would like to share at this time: _____

_____

_____