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New Client Information Form

Date:_______________

Full Name _________________________________ Name You Prefer ___________________________

Date of Birth___________________ Age_______ Email ___________________________________

Address ____

Check Preferred Phone

D **Home (________) _________________________ Okay to leave message? Yes / No**

D **Work (________) _________________________ Okay to leave message? Yes / No**

D **Cell (________) _________________________ Okay to leave message? Yes / No**

Emergency Contact _______________________ Relationship to You ___________________________

Address____

Phone (________)_________________________

Relationship Status: ____Single _____ Committed Rel. ___ Married _____ Separated _____Divorced ____ Widowed

Education _______________________________ Occupation _________________________________

Employer____

Referred by: __________________________________ May I thank them? ____ yes ____no

Service you are requesting: _____Individual Therapy _____Couples Therapy _____Family Therapy

Please list everyone living in your household and their relationship to you:

Name	**Age**	**Gender**	**Relationship to You**

Please briefly describe concerns or problems that bring you to therapy at this time:

Please circle any of the following areas of concern, either past or present:

Alcohol/Drug Abuse	Hopelessness	Paranoia	Anger Control
Obsessive Thoughts	Parenting Concerns	Anxiety	Hostility
Phobias	Assertiveness	Isolation	School Problems
Attention/Concentration	Impulse Control Problems	Bereavement/Grief	Self-Defeating Behaviors
Insomnia	Self-Esteem Issues	Communication	Excessive Irritability
Self-Injurious Behaviors	Depression	Identity Issues	Sexual Abuse
Dissociation	Legal Issues	Sexuality	Spirituality
Domestic Violence	Marital /Relationship Problems	Stress	Eating/Food Issues
Medical Concerns	Suicidal Thoughts	Memory	Family Problems
Work Problems	Hallucinations (seeing or hearing things)	Panic Attacks	Excessive Worrying
Sexual Concerns	Delusions (implausible beliefs)		

Other Concerns: ____

Medical Problems: ____

Primary Physician: ____________________ **Date of Last Visit:**____________________

Have you been in counseling or therapy before? Yes No

Date **Nature of Problem** **Therapist** **Benefit from therapy?**

Current medications:

Medication **Dosage** **Reason for Use** **Prescribing Physician**

Please describe use of alcohol or other substances:

Substance **Frequency of Use**

Please list anyone in your family who has been in therapy or diagnosed with any type of mental illness:

Relationship to You **Problem** **Nature of Treatment, if any**

Is there anything else you would like me to know?

____

Client Signature **Date**