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NEW CLIENT INFORMATION FORM

Welcome to my practice. Please take a few minutes and fill out the following form. This information will enable me to better meet your needs. Thank you for your time.

Client Name: _____

Today's Date: _____

(To be completed by the parent/guardian if patient is younger than 18 years)

Date of Birth: _____ Age: _____

Address:

Street address _____

City _____ State _____ Zip _____

Email Address: _____

I do not wish to receive emails ☐

Phone Number(S): Home:_____Work:_____-
Cell:_____

May I call you … at home? Yes No … at work? Yes No

Current Relationship Status: Single Married-Date: _____

Co-habitating-Date: _____ Seperated-Date:_____

Widowed-Date: _____

Prior Marriages: Please list all prior marriages, including the date of marriage and date of divorce

_____

_____

_____

Please list all of your children:

Name_____ Age_____ In Home_____Y_____N

Name_____Age_____ In Home_____Y_____N

Name_____Age_____ In Home_____Y_____N

Name_____Age_____In Home_____Y_____N

Employer/School:_____Occupation:_____

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Referred by: _____

Person to be contacted in case of an emergency:

Name: _____Relationship: _____

Home Phone: _____Work Phone: _____

New Patient Information/Consent Form

Presenting Problem(S):

Please describe your reasons for seeking counseling (include date/month the problem started):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any serious medical conditions that you are experiencing or have been treated for:

_____
_____
_____
_____
_____

Please list current and past medications that you have taken:

_____
_____
_____

When did you last have a physical examination?

_____

Who did you see? Name: _____

Phone Number: _____

Trauma History:

Physical Abuse	Yes No	Victim of Violent Crime	Yes No
Emotional Abuse	Yes No	Domestic Violence	Yes No
Sexual Abuse	Yes No	Other Incident	Yes No

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Substance Use:

Is there a family history of substance abuse? If yes, please describe:

_____
_____
_____

Substances: (please indicate if you use any of the following substances)

Coffee/caffeine _____Cups/Day Alcohol _____drinks per week

Cigarettes per day _____ For how long? _____

Illegal Drugs: (If yes, please list type, amount and how often)_____
_____

Most recent use of any illegal drugs: _____

How many years of use: _____

Has anyone ever told you that your use of substance is a problem? Yes No

Which ones? _____

Have you ever received any kind of substance abuse treatment? Yes No

If yes, please describe and give dates: (i.e., 12 steps, IOP, Detox)

_____
_____

Psychiatric History:

Is there any family history of psychiatric illness or treatment? Yes No

If yes, please explain:

_____
_____
_____

Have you ever been to see a psychiatrist or therapist before today? Yes No

Please add any information that you would like me to know that is relevant to your treatment:

_____
_____
_____
_____
_____
_____

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PROBLEM CHECKLIST

Rate the following areas in which problems currently exist.

0=NONE 1=MILD 2=MODERATE 3=SERIOUS 4=SEVERE

0 1 2 3 4 Constant worry
0 1 2 3 4 Nightmares
0 1 2 3 4 Memory problems
0 1 2 3 4 Withdrawal from others
0 1 2 3 4 Fear of being in public
0 1 2 3 4 Feel anxious
0 1 2 3 4 Loneliness
0 1 2 3 4 Repetitive behaviors

0 1 2 3 4 Anxious or on edge
0 1 2 3 4 Problem Solving
0 1 2 3 4 Indecisiveness
0 1 2 3 4 Episodes of panic
0 1 2 3 4 Phobias
0 1 2 3 4 Trouble making friends
0 1 2 3 4 Unwanted distressing thoughts
0 1 2 3 4 Troublesome thoughts/feelings

0 1 2 3 4 Previous episodes of depression
0 1 2 3 4 Feel sad
0 1 2 3 4 Feel hopeless
0 1 2 3 4 Feel irritable
0 1 2 3 4 Think about suicide
0 1 2 3 4 Not able to have fun
0 1 2 3 4 Unmotivated to complete tasks

0 1 2 3 4 Previous episodes of elation
0 1 2 3 4 Cry easily
0 1 2 3 4 Fe el guilty
0 1 2 3 4 Feel worthless
0 1 2 3 4 Past suicide attempts
0 1 2 3 4 No interest in usual pleasures
0 1 2 3 4 Loss of interest in sex

0 1 2 3 4 Sexual performance problems
0 1 2 3 4 Chronic pain
0 1 2 3 4 Worry over health
0 1 2 3 4 Skipped menstrual periods
0 1 2 3 4 Loss of energy
0 1 2 3 4 Body feels slowed down
0 1 2 3 4 Body feels sped up
0 1 2 3 4 Unhappy with weight
0 1 2 3 4 Binge eating
0 1 2 3 4 Trouble falling asleep
0 1 2 3 4 Trouble staying asleep

0 1 2 3 4 Bowel disturbances
0 1 2 3 4 Ongoing laxative use
0 1 2 3 4 Medical problems
0 1 2 3 4 Confusion
0 1 2 3 4 Fatigue
0 1 2 3 4 Thoughts feel slowed down
0 1 2 3 4 Racing thoughts
0 1 2 3 4 Recent weight loss or gain
0 1 2 3 4 Intentional vomiting
0 1 2 3 4 Sleeping too much
0 1 2 3 4 Waking up too early

0 1 2 3 4 Hear voices
0 1 2 3 4 See things that others don't see
0 1 2 3 4 Fits of rage
0 1 2 3 4 Poor self control
0 1 2 3 4 Relationship problems
0 1 2 3 4 Problems with money
0 1 2 3 4 Legal problems

0 1 2 3 4 Paranoid thoughts
0 1 2 3 4 Strange thoughts
0 1 2 3 4 Think about hurting someone
0 1 2 3 4 Work problems
0 1 2 3 4 Problems with food
0 1 2 3 4 Problems at home

Any areas of concern not mentioned above?_____

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INSURANCE INFORMATION

Please complete the following regarding your insurance carrier.

We would also like a copy of your insurance card.

Primary insurance type: _____

Insurance phone number: _____

Claims address: _____

Subscriber name: _____

Sex: (circle one) Male or Female Date of Birth: _____

Subscriber ID: _____

Group #: _____

Subscriber's employer: _____

Deductible: $ _____ Copayment: $ _____

Relationship to subscriber: (circle one)

Self Spouse Child Other