Julia C. Kitts,LCSW 12625 High Bluff Dr. #111
LCS18488 San Diego, CA 92130

NEW CLIENT INFORMATION FORM

TODAY'S DATE________________________
CLIENT NAME:
FIRST:______________________________MIDDLE :____________________LAST:____
MAILING
ADDRESS:____CITY:_______________STATE:_______ZIP:_______________

HOME PHONE: ________________________________WORK PHONE:_______________________________________

CELL PHONE:__________________________________ BIRTHDATE:____________________ AGE:_______ SEX: M / F

SOCIAL SECURITY #:____________________________DRIVER'S LICENSE #:___________________

MARITAL STATUS: Single Married Divorced Separated Widowed
EMPLOYMENT STATUS: Full-Time Part-Time Retired None Self Employed Active Military
STUDENT STATUS: Full-Time Part-Time N/A

RESPONSIBLE PARTY INFORMATION
(*Only IF Different from Client Information Above)*
NAME:
FIRST:_______________________MIDDLE :____________________LAST:____

BILLING ADDRESS:___________________________________CITY:________________STATE:_______ZIP:________________

HOME PHONE: ________________________________WORK PHONE:_______________________________________

CELL PHONE:____________________________________BIRTHDATE:___________________AGE:_________SEX: M/F
RELATIONSHIP OF CLIENT TO RESPONSIBLE PARTY: Spouse Child Other(Specify)____________

SOCIAL SECURITY #:_______________________________ DRIVER'S LICENSE #:______________________________

INSURANCE INFORMATION
(Please Provide Copies of ALL I.D. Cards . FRONT and BACK, If Applicable)
If You Have No Insurance and You Will Be Solely Responsible For Payment Check Here_____________ (*Skip to the next page*).

PRIMARY INSURANCE NAME:____
EFFECTIVE DATE:________________________ INSURANCE PHONE NUMBER:________________________
CLAIMS ADDRESS:____
CITY:____STATE:____________ZIP:______________________
SUBSCRIBER'S NAME:____SEX: M/ F DATE Of BIRTH:______________

SUBSCRIBER'S I.D. #:________________________________ **GROUP #:**________________________________
SUBSCRIBER'S EMPLOYER;____________________________DEDUCTIBLE $:_________________COPAYMENT $:_______________
RELATIONSHIP OF CLIENT TO SUBSCRIBER: Self Spouse Child Other _______________

SECONDARY INSURANCE NAME:____
EFFECTIVE DATE:________________________ INSURANCE PHONE NUMBER:_______________________
CLAIMS ADDRESS:____
CITY:____ STATE:___________ ZIP:_______________________
SUBSCRIBER'S NAME:____SEX: M/ F DATE OF BIRTH:__________________

SUBSCRIBER'S I.D. #:____________________________ GROUP #:__________________________
SUBSCRIBER'S EMPLOYER:______________________________DEDUCTIBLE $:_________________ COPAYMENT $:________________
RELATIONSHIP OF CLIENT TO SUBSCRIBER: Self Spouse Child Other _______________

NEW CLIENT INTAKE/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______________________________ M/ F Today's Date_____________

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

Date of Birth____________________ Age:__________________

Address ____

City: _____________________________State:_________ Zip:_________________

Email Address:____

Do you wish to receive emails: Yes/No

Phone: H)_____________________W):____________________ C): ______________________

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

Emergency Contact__________________________________ Phone _____________________

Current relationship Status: Single Married- Date:______________

Co-habitating –Date:__________________ Separated- Date_______________

Divorced- 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

Social Support System:____

Employer/School:____

Occupation:____

Referred by:____

Person to be contacted in case of an emergency:

Name:______________________________ Relationship:________________________________

Home Phone:________________________ Work Phone:__________________________________

New Client Information/Consent Form

Presenting Problem(s):

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

____

____

____

____

____

____

____

____

____

____

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

If Yes to any above briefly describe:___________________________________

____

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 the 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 any 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:____
____

____

____

Psychiatric History (Cont'd):

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

If yes, when was the treatment: ____

____

____

For how long and if you stopped, why?_____________________________________
____
Name of provider(s) ____

Were any ***medications*** ever prescribed to you by a psychiatrist/other provider (PCP, OB-GYN, Nurse Practitioner) for any psychiatric illness/symptoms?
□Yes □No

If yes:
What ***previous*** medications were you prescribed? (no longer taking):
____
____
Your Response: ____
____
Why did you stop taking these medication(s)?________________________________
____

Current Prescription Medications including dosage and frequency:
1) ________________________________ 2)__________________________________
3) ________________________________ 4)__________________________________
5)____________________________ _____ 6)__________________________________

Over the Counter Medications/Supplements/Herbs:
Medication: Dose: How Often:

____

____
____
____

Do you have any allergies to medications? Yes/No
If yes, please list medications:____
____

Have you ever been hospitalized in a psychiatric facility? □Yes □No

Hospital(s):____
Dates:____

Reason for Admission(s):____
Length of stay:____

Medical History:
Please list any medical conditions and/or illnesses for which you are currently being treated or have been treated for in the past and give dates of treatment:
____
____
____
____
When was your last physical exam and by whom?_____________________
____
If you have ever had surgery, please list below:
____ Date:______________
____ Date:______________
____ Date:______________
Please add any information that you would like me to know that is relevant to your treatment:
____
____
____
____
____
____

PROBLEM CHECKLIST

Please list which of the problems listed below are bothering you at this time.

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

0 1 2 3 4 Previous episodes of depression
0 1 2 3 4 Previous episodes of elation
0 1 2 3 4 Feel Sad
0 1 2 3 4 Cry easily
0 1 2 3 4 Feel hopeless
0 1 2 3 4 Feel guilty
0 1 2 3 4 Feel irritable
0 1 2 3 4 Feel anxious
0 1 2 3 4 Feel worthless
0 1 2 3 4 Think about suicide
0 1 2 3 4 Past suicide attempts
0 1 2 3 4 Not able to have fun
0 1 2 3 4 Loss of interest in usual pleasures
0 1 2 3 4 Unmotivated to complete tasks

0 1 2 3 4 Loss of interest in sex
0 1 2 3 4 Sexual performance problems
0 1 2 3 4 Confusion
0 1 2 3 4 Loss of energy
0 1 2 3 4 Fatigue
0 1 2 3 4 Body feels slowed down
0 1 2 3 4 Thoughts feel slowed down
0 1 2 3 4 Body feels sped up
0 1 2 3 4 Racing thoughts
0 1 2 3 4 Hear voices
0 1 2 3 4 Suspiciousness/Paranoid thoughts
0 1 2 3 4 See things that aren't there
0 1 2 3 4 Strange thoughts
0 1 2 3 4 Fits of rage
0 1 2 3 4 Think about hurting someone
0 1 2 3 4 Poor self-control
0 1 2 3 4 Work problems
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 Nightmares
0 1 2 3 4 Problems concentrating
0 1 2 3 4 Memory problems
0 1 2 3 4 Indecisiveness
0 1 2 3 4 Withdrawal from others
0 1 2 3 4 Episodes of panic
0 1 2 3 4 Fear of being in public
0 1 2 3 4 Phobias
0 1 2 3 4 Fear of weight gain
0 1 2 3 4 Trouble making friends
0 1 2 3 4 Loneliness
0 1 2 3 4 Unwanted, distressing thoughts
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Troublesome dreams, nightmares, feelings about traumatic events
0 1 2 3 4 Constant worry
0 1 2 3 4 Anxious, on edge
0 1 2 3 4 Bowel disturbances
0 1 2 3 4 Ongoing laxative use
0 1 2 3 4 Chronic pain
0 1 2 3 4 Worry over health
0 1 2 3 4 Medical problems
0 1 2 3 4 Skipped menstrual periods
0 1 2 3 4 Unhappy with weight
0 1 2 3 4 Recent weight gain or loss
0 1 2 3 4 No appetite
0 1 2 3 4 Binge eating
0 1 2 3 4 Intentional vomiting
0 1 2 3 4 Trouble falling asleep
0 1 2 3 4 Sleeping too much
0 1 2 3 4 Trouble staying asleep
0 1 2 3 4 Waking up too early
0 1 2 3 4 Problems with food
0 1 2 3 4 Problems at home