

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/PREFERRED PRONOUNS: _____

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/PREFERRED PRONOUNS: _____

RELATIONSHIP OF CLIENT TO RESPONSIBLE PARTY: Spouse Child Other(Specify) _____

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/Noat work? Yes/No

Emergency Contact _____ Phone _____

Current relationship Status: Single Married- Date: _____

Co-habiting -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