

New Client Information Form

Date: _____ Social Security Number: _____

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Cell Phone: _____

Best number to leave a message: _____ (needs to be unblocked)

E-Mail Address: _____ (OK for messages) _____

Address: _____
Street address

_____ City State Zip

Education (last grade or degree complete): _____

Employer: _____ Position: _____

Relationship Status:

____ Single ____ Married ____ Partner ____ Divorced ____ Widowed

If married, or a partner, name? _____ Age: _____

How would you rate your relationship (1 lowest and 10 highest): _____

Years together: _____ Any concerns with relationship: _____

Any Children? If yes, names and ages: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

What brings you in today: _____

New Client Information- (Cont.)

Please list the names and relationships of the three most important people in your life and why:

1. _____

2. _____

3. _____

Who is your primary physician, address, and phone number: _____

How would you rate your overall physical health?

___ Excellent ___ Great ___ Good ___ Fair ___ Poor

Explain if health problems: _____

List current medications, dosage amount, and purpose:

Do you smoke? ___ If yes, how many cigarettes a day: ___ Age started: ___

Do you have any sleep problems? ___ If Yes, explain: _____

Alcohol drinks a days/week _____ Any recreational drugs: _____

Are you dealing with any past or current addictions? ___ Yes ___ No

If yes, please describe hospitalizations or treatments _____

Any prior therapy? ___ If yes, dates & with whom: _____

Was therapy helpful? ___ Any comments: _____

Do you exercise: ___ If yes, type & how often: _____

New Client Information (Cont.)

Do you have issues with Depression, Anxiety, ADD or ADHD? _____
If yes, please describe: _____

Any family history of Depression or Anxiety: _____ If so, who / describe: _____

Are you currently feeling suicidal: _____ Have you ever felt suicidal if the past _____
If so, list dates, any hospitalization dates if applicable: _____

Do you have a history of abuse? (physical, sexual, emotional) _____
If yes describe: _____

Please circle any concerns/problems that apply:

- | | | | |
|---------------------------|---------------|----------------|-------------|
| Low self-esteem | Tense | Irritable | Restless |
| Difficultly Concentrating | Fears | Nightmares | Flashbacks |
| Mood Swings | Panic Attacks | Sexual Matters | food/weight |
| Compulsive | Shy | Work Issues | Fatigue |
- Any other problems: _____

What do you consider to be your strengths: _____

What do you consider to be your weaknesses: _____

What do you do for fun: _____

Spiritual orientation: _____

Any concerns about our sessions, or, anything else I should know : _____

How did you hear about me: _____

Signature: _____ **Date:** _____