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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 have any sleep problems? _______If Yes, explain: _______________________
____

Alcohol drinks a days/week______________Any recreational drugs: ______________

Are you or your family 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________________________
____

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:** ___________________