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NEW CLIENT INFORMATION FORM

Please complete this form as thoroughly as possible. The information that you provide is extremely useful in understanding you, your history and your goals for treatment. If you prefer not to answer a particular item, please skip it. This information will be treated in the same confidential manner as the topics discussed in therapy sessions.

CLIENT DEMOGRAPHIC AND CONTACT INFORMATION

Name:_____ Date: _____
SSN: _____ Birth Date: ____/_____/_____ Age: _____
Gender: [ ] Female [ ] Male [ ] Transgender [ ] Other
Sexual Orientation: [ ] Bisexual [ ]Gay [ ] Heterosexual [ ] Lesbian [ ] Other [ ] Prefer not to answer
Race/Ethnicity: _____

Local address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (____)_____ Is it okay to leave a message? [ ] Yes [ ] No

Guardian/Parent (if under 18): _____

Emergency contact: Name: _____ Relationship: _____
Address:_____
Phone: (___)_____ Email: _____

Email: _____ Okay to contact via email?: [ ] Yes [ ] No

- *Please note e-mail is not a secure means of communication. Therefore, confidentiality cannot be guaranteed. Email contact may only be used for scheduling purposes, distribution of surveys/newsletters and in case of emergency. Email is not an appropriate medium for discussing clinical concerns.*

Referral source: _____ May we contact to thank for referral? [ ] Yes [ ] No

THERAPY NEEDS/HISTORY

What has led you to seek therapy at this time? :

_____

_____

How long has current issue been a problem?: _____

What are your desired outcomes for counseling?:

_____

_____

How have you attempted to address these concerns in the past?:

_____

_____

HEALTH/MEDICAL HISTORY

1.How is your physical health at present?

[ ] Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very good

2.Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3.Please list any medications you are taking and your prescribing physician's name:

_____

4.Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□ Other _____

5.How many times per week do you exercise? _____

Approximately how long each time? _____

6.Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Restricting □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

7.In a typical month, how often do you have 4 or more alcoholic drinks in a 24-hour period? _____

8.How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

9.Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

10. Have you now or in the past engaged in self-harm behaviors (e.g., cutting, scratching, burning)?
□ Frequently □ Sometimes □ Rarely □ Never

11. Have you ever had thoughts of physically harming another person? □ Yes □ No
Have you ever acted on these thoughts? □ Yes □ No

SOCIAL HISTORY

12.Please list any significant changes/stressors that have occurred within the past year:
_____

13.Do you feel that you have adequate social/emotional support from others? [ ] No [ ] Yes

14. Please list your important hobbies: _____

15.Are you currently employed or in school? [ ] No [ ] Yes
If yes, please list where employed or in school: _____
How satisfied are you with your employment or educational experiences currently?:
[ ] Not at all [ ] Somewhat satisfied [ ] Satisfied [ ]Very satisfied

16.Any current legal problems? [ ] No [ ] Yes

FAMILY HISTORY (please use N/A if not applicable)

	Name	Age	Occupation	Quality of relationship (Excellent, Good, Fair, Poor)	Health/Mental Health History
Mother					
Father					
Step-Parent					
Siblings					
Partner/Spouse					
Children					
Important Relative					