New Client Information Form

Please provide the following information and answer the questions below. All information provided is kept confidential as part of your clinical record. Please use the reverse side of the page for more room if needed.

Please fill out this form and bring it to our first session.

Name: _____ Date of Birth: _____

Name of parent/guardian (if under 18 years): _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip Code)

Preferred phone number: _____ Type: ☐ Work ☐ Cell ☐ Home

Is it safe to leave a message? ☐ Yes ☐ No

Email: _____ Is it safe to email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered a confidential form of communication

Marital Status: ☐Never married ☐ Married ☐ Domestic Partnership
☐Separated ☐ Divorced ☐ Widowed

Please list any children and their age: _____

_____

Referred by (if applicable): _____

Occupation and Employer:_____

Level of education completed and degree earned: _____

_____

What are your current living arrangements (roommates, family, rent, own)?
_____

General Health and Mental Health Information

Have you previously received any type of mental health treatment? ☐ Yes ☐ No
If so, please list previous clinician(s) and dates of treatment:

_____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If so, please list dates and place of hospitalization: _____

_____

Are you currently taking or have you ever been prescribed and taken psychiatric medication?
☐ Yes ☐ No If yes, please describe what medications and dosage, and duration taken:

_____

_____

Are you currently seeing a psychiatrist? ☐ Yes ☐ No
If yes, please list his or her name and contact information. A release will be needed to coordinate care.

_____

Are you currently taking any other prescription medication? ☐ Yes ☐ No
If so, please list reason, medication, and dosage:

_____

_____

Have you ever tried to commit suicide, thought about it, or made a plan? ☐ Yes ☐ No
If yes, please provide more information, including the date of your last attempt:

_____

_____

How would you describe your overall health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list, and describe if desired, any health problems you are currently experiencing:

_____

On average, how much sleep do you get a night? _____

How would you rate your current sleep habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any current sleep problems you are currently experiencing:

_____

How many times a week do you generally exercise? _____

In what type of exercise do you participate? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

How many nights a week do you drink? _____

How many drinks do you have in one sitting? _____

How frequently do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Have you ever received inpatient treatment for substance use? ☐ Yes ☐ No

If so, please list the name of the program and dates of treatment: _____

_____

Are you currently experiencing: ☐ grief, ☐ overwhelming sadness, or ☐ depression?

If so, when did you start feeling this way?_____

Are you currently experiencing ☐ anxiety, ☐ panic attacks, or ☐ phobias?

If so, when did you start feeling this way? _____

Are you currently in a romantic relationship? ☐ Yes ☐ No

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If so, how long have your been in your relationship? _____

How would you rate your relationship on a scale of 1-10? _____

Please briefly describe what is motivating you to seek therapy:

_____

_____

_____

Have you ever experienced a traumatic event, such as child abuse or neglect, child sexual abuse, witnessing domestic violence as a child, being in an abusive relationship as an adult, or have you been sexually assaulted? A traumatic event may also include being the victim of a crime, surviving a natural disaster, house fire, or the unexpected death of a loved one.
If you check yes, we will explore this/these experiences to the degree you feel comfortable within the first three sessions. If you wish, you may circle the above incidents you have experienced or list them here. ☐ Yes ☐ No

_____

_____

FAMILY MENTAL HEALTH HISTORY:

Please identify below whether or not you have any family history of any mental health issues. Please write in the person's relationship to you in the space provided (mother, father, grandmother, uncle, brother, etc).

	Please Circle	Family Member
Depression	Yes/ No	_____
Anxiety	Yes/ No	_____
Drug Use	Yes/ No	_____
Alcohol Abuse	Yes/ No	_____
Domestic Violence	Yes/ No	_____
Eating Disorders	Yes/ No	_____
Obsessive Compulsive Disorder	Yes/ No	_____
Schizophrenia	Yes/ No	_____
Suicide Attempt	Yes/ No	_____

ADDITIONAL INFORMATION:

What are your spiritual or religious beliefs, if any? How do you practice your beliefs? Do you attend a house of worship or have any regular spiritual or religious practices?

_____

_____

_____

Would you like your spirituality or religion incorporated into your treatment as a source of strength and support? If you are not sure, we can discuss what this might look like based on your comfort level.

_____

_____

_____

What do you hope therapy will help you accomplish? _____

_____

_____

_____

_____

What concerns or questions do you have for me? _____

_____

_____

_____

_____

_____