NEW CLIENT INFORMATION FORM

Date _____

PERSONAL INFORMATION				
LAST NAME	FIRST NAME (LEGAL)	PREFERRED NAME	D.O.B.	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE ☐ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ☐ FEMALE ☐ MALE	WHAT IS YOUR GENDER IDENTITY? ☐ SAME AS SEX LISTED WITH INSURANCE ☐OTHER_____	PREFERRED PRONOUNS ☐ SAME AS SEX LISTED WITH INSURANCE ☐OTHER_____	
PERMANENT STREET ADDRESS		CITY	STATE	ZIP CODE / COUNTY
HOME PHONE _____ CAN WE LEAVE A VOICE MAIL? ☐ YES ☐ NO	CELL PHONE _____ CAN WE LEAVE A VOICE MAIL ☐YES ☐NO CAN WE TEXT TO THIS NUMBER? ☐ YES ☐ NO	EMAIL ADDRESS _____ CAN WE CONTACT YOU VIA E-MAIL ☐YES ☐NO		
TEMPORARY ADDRESS (IF APPLICABLE)		CITY	STATE	ZIP CODE / COUNTY
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	CHILDRED / AGES Biological#_____ Age(s)_____ Step#_____ Age(s)_____ Adopted#_____ Age(s)_____	OTHER MEMBERS OF THE HOUSEHOULD (If applicable)		

EMERGENCY CONTACT	
NAME: (Last Name, First Name)	EMAIL:
RELATIONSHIP:	PHONE NUMBER:

EMPLOYMENT			
OCCUPATION:	FULL-TIME	PART-TIME	RETIREMENT DATE
EMPLOYER NAME:	RETIRED	STUDENT	

PRIMARY INSURANCE				
RELATIONSHIP TO PATIENT	SUBSCRIBER NAME	SEX	D.O.B.	EMPLOYER
INSURANCE PROVIDER	SOCIAL SECURITY OF THE INSURED	POLICY NUMBER	GROUP ID / PLAN NUMBER	

COUNSELING INFORMATION
CURRENT THERAPY TREATMENT
REFERRING PHYSICIAL (IF ANY):
HOW DID YOU HEAR ABOUT US?
CHIEF COMPLAINT: What is the reason you are seeking counseling?
HOW LONG HAVE YOU BEEN EXPERIENCING THIS ISSUE?

PREVIOUS TREATMENT
HAVE YOU ENGAGED IN COUNSELING / THERAPY FOR THIS ISSUE PREVIOUSLY? YES, please explain ☐ YES ☐ NO
WHEN?_____
WHERE / WITH WHOM?_____

HAVE YOU EVER ENROLLED INTO A PROGRAM PREVIOUSLY? YES, please explain ☐ YES ☐ NO

TYPE OF PROGRAM? Outpatient Psychotherapy___ Inpatient Psychiatric___Outpatient Substance Abuse___Inpatient Substance Abuse____Self-Help/Peer Grp____

WHEN?_____

WHERE / WITH WHOM?_____

MEDICATION PRESCRIBED? _____ IF YES, RESPONSE WAS POSITIVE OR NEGATIVE?_____

IMPACT OF THE PROBLEM

HOW SERIOUS IS THE PROBLEM AND WHAT IMPACT IS IT HAVING ON VARIOUS ASPECTS OF YOUR DAY-TO-DAY LIFE? Please rate each below category	1 = lowest / list impact to the category listed 10 = highest / very strong impact to the category									
MARRIAGE / PARTNER	N/A	1	2	3	4	5	6	7	8	9	10
RELATIONSHIP WITH CHILDREN	N/A	1	2	3	4	5	6	7	8	9	10
ABILITY TO PARENT	N/A	1	2	3	4	5	6	7	8	9	10
RELATIONSHIP WITH OTHER FAMILY MEMBERS	N/A	1	2	3	4	5	6	7	8	9	10
RELATIONSHIP WITH FRIENDS	N/A	1	2	3	4	5	6	7	8	9	10
WORK PERFORMANCE	N/A	1	2	3	4	5	6	7	8	9	10
RELATIONSHIP WITH CO-WORKERS / COLLEAGUES	N/A	1	2	3	4	5	6	7	8	9	10
FINANCES	N/A	1	2	3	4	5	6	7	8	9	10
LEGAL REMAFICATIONS	N/A	1	2	3	4	5	6	7	8	9	10
SPIRITITUALITY	N/A	1	2	3	4	5	6	7	8	9	10
HEALTH	N/A	1	2	3	4	5	6	7	8	9	10

GENERAL HEALTH

HAVE YOU BEEN PREVIOUSLY HOSPITALIZED FOR A MENTAL INLESS? YES, please explain ☐ YES ☐ NO

WHEN?_____

WHERE?_____

FOR WHAT CONDITION?_____

HAVE YOU EVER ATTEMPTED SUICIDE? YES, please explain ☐ YES ☐ NO

ARE YOU CURRENTLY HAVING ANY SUICIDAL THOUGHTS? YES, please explain ☐ YES ☐ NO

ANY ISSUES WITH MAINTAINING A HEALTHLY APPETITE? YES, please explain ☐ YES ☐ NO

ANY ISSUES WITH SLEEPING? YES, please explain ☐ YES ☐ NO

SIGNIFICANT HEALTH ISSUES? YES, please explain ☐ YES ☐ NO

CURRENT CONDITION OR POTENTIAL SYMPTOMS WHICH MAY WARRANT FURTHER MEDICAL ATTENTION? YES, please explain ☐ YES ☐ NO

PHYSICAL HANDICAP? YES, please explain ☐ YES ☐ NO

MEDICATION NAME (IF MORE THEN 5, PLEASE ATTACH WITH THE FORM)	START DATE	END DATE / REFILL DATE	DOSAGE	DOCTOR / LAST SEEN
1)				
2)				
3)				
4)				
5)				

ALCOHOL ABUSE

ALCOHOL INTAKE FREQUENCY? ☐ NEVER ☐ DAILY ☐ 3 - 4 TIMES A WEEK ☐ MONTHLY ☐OCCASIONAL

HAVE YOU NOTICED AN INCREASE IN TOLERANCE? (Please explain)_____

ADDITIONAL DETAILS_____

DO YOU HAVE DIFFICULTY STOPPING AFTER FIRST DRINK? ☐ YES ☐ NO (IF YES, PLEASE EXPLAIN)

ADDITIONAL DETAILS_____

TYPE OF ALCOHOL PREFERENCE ? ☐ N/A ☐ BEER ☐ MIX DRINKS ☐ HARD LIQUOR ☐ OTHER (PLEASE SPECIFY)

ADDITIONAL DETAILS_____

ALCOHOL CONSUPTION PER SITTING? ☐ N/A ☐ 1 - 2 DRINKS ☐ 3 - 4 DRINKS ☐5 OR MORE

ADDITIONAL DETAILS_____

ALCOHOL RELATED PROBLEMS? (PLEASE INDICATE AS APPROPRIATE) ☐ N/A ☐ FAMILY ☐ SOCIAL ☐WORK ☐ PERSONAL

☐ SLEEP ☐ BLACKOUTS / PASSING OUT / SEIZURES ☐ WITHDRAWALS ☐ COMPLICATIONS WITH MEDICATION

ADDITIONAL DETAILS_____

LENGTH OF ALCOHOL RELATED PROBLEMS? ☐ 1 MONTH OR LESS ☐ 6 MONTHS OR LESS ☐ 1 YR OR LESS ☐ LONGER THEN 1 YR ☐ LONGER THEN 5 YRS

ADDITIONAL DETAILS_____

ALCOHOL RELATED TREATMENT ATTEMPTS? ☐N/A ☐AA (OR SIMILAR PROGRAM) ☐ OUTPATIENT ☐ COMMUNITY ☐ SELF

ADDITIONAL DETAILS_____

SUBSTANCE ABUSE	AMOUNT	FREQUENCY		
DO YOU USE ANY OF THE FOLLOWING?	VOLUME?	DAILY	WEEKLY	OCCASIONALLY
MARIJUANA				
HEROIN				
COCAINE				
CRACK				
OTHER? (Please explain below)				

OTHER (If applicable)_____

ADDITIONAL DETAILS_____