NEW CLIENT INFORMATION FORM

Date _____

PERSONAL INFORMATION					
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		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	CHILDREN / AGES Biological#_____ Age(s)_____ Step#_____ Age(s)_____ Adopted#_____ Age(s)_____	OTHER MEMBERS OF THE HOUSEHOLD (If applicable)			

EMERGENCY CONTACT	
NAME:	EMAIL:
RELATIONSHIP:	PHONE NUMBER:

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

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

COUNSELING INFORMATION
CURRENT THERAPY TREATMENT
REFERRING PHYSICIAN (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?_____
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___

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 / least 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 RAMAFICATIONS	N/A	1	2	3	4	5	6	7	8	9	10
SPIRITUALITY	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 ILLNESS? 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 HEALTHY 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

ARE YOU TAKING ANY MEDICATION? YES, please provide details below: PLEASE PROVIDE ATTACHED LIST IF GREATER THEN 5 ☐ YES NO

1) MEDICATION NAME_____ DOSAGE_____ START DATE __ /__ /__ END DATE / REFILL DATE_____ DOCTOR_____ LAST SEEN __ /__ /__

2) MEDICATION NAME_____ DOSAGE_____ START DATE __ /__ /__ END DATE / REFILL DATE_____ DOCTOR_____ LAST SEEN __ /__ /__

3) MEDICATION NAME_____ DOSAGE_____ START DATE __ /__ /__ END DATE / REFILL DATE_____ DOCTOR_____ LAST SEEN __ /__ /__

4) MEDICATION NAME_____ DOSAGE_____ START DATE __ /__ /__ END DATE / REFILL DATE_____ DOCTOR_____ LAST SEEN __ /__ /__

5) MEDICATION NAME_____ DOSAGE_____ START DATE __ /__ /__ END DATE / REFILL DATE_____ DOCTOR_____ LAST SEEN __ /__ /__

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 THAN 1 YR ☐ LONGER THAN 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_____