NEW CLIENT INFORMATION

Today's Date___________________
Referred By____________________

Client Name____________________________________Age________DOB__________________
Address____
Telephone Numbers (H)________________(W)__________________(C)___________________

Do I have your permission to leave a message on any of the above phone numbers?_________

Emergency Contact____Phone Number_____________
Physician's Name____Phone Number_____________

Do I have your permission to contact your physician? A written release is required._________

PERSONAL HISTORY

Marital Status_________Date of Marriage___________Prior Marriages/How long?__________
Current Religious Preference______________________Childhood Religion___________________
Ethnic Background__________________________Where were you born______________________
Who do you currently live with?____
____

HISTORY OF PRESENTING PROBLEM

Please describe the problem(s) that prompted you to seek counseling at this time______________

____

____

What do you hope to gain from counseling?____

____

SYMPTOM LIST: Check all that apply at this time

___depressed	___angry	___exhausted	___difficulty sleeping
___anxious	___tearful	___eating problems	___easily overwhelmed
___alcohol use	___drug use	___low energy	___low self esteem
___forgetful	___irritable	___sad	___low sex drive
___ashamed	___bad temper	___suicidal thoughts	___poor follow through
___worried	___memory loss	___irritable	___easily overwhelmed

LIFE STRESSORS: Please check all that apply within the last year.

___Financial problems
___Major health problems
___Legal problems
___Recent move / relocation
___Job dissatisfaction
___Death of a family member or close friend
___Marital / Relationship problems
___Problems at work
___Problems with relatives or friendships
___Problems at school

Please explain all that you have checked____
____
____

Please identify other current sources of stress in your life ________________________________
____

MEDICAL HISTORY: Please check all that apply.

___Headaches
___Cancer
___Arthritis
___Thyroid disease
___Intestinal problems
___Diabetes
___Heart disease
___head injury / concussion
___Stomach problems
___Reproductive problems
___Major surgery
___Car accident

Please explain all that you have checked____
____
Please identify other medical issues not listed above ____________________________________
____
Please list medications____

PAST PERSONAL HISTORY: Please check all that were true when you were a child or teen.

___Parents argued frequently
___Parents divorced (or were never married)
___Had one or more step parents
___Death of a parent
___Death of a family member other than a parent
___Lived in an orphanage or foster care
___Was abused, either physically, emotionally or sexually (including rape or molestation)
___A family member was disabled, seriously ill or mentally ill for a period of time
___Was shy, lonely or isolated
___Felt teased or ridiculed by others
___One or more parent had a drinking / drug problem
___One or more grandparent had a drinking / drug problem
___Got into trouble frequently
___Was extremely responsible
___Had problems with temper
___Had difficulty with sexual identity