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NEW CLIENT INFORMATION

Today's date: _____

A. Identification

First name: _____ Middle initial: _____ Last name: _____

Nicknames or aliases: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell phone:_____

Email address: _____

Spouse/Partner name: _____ Phone: _____

Children's names and ages: _____

Insured's name: _____ Insured's birth date:_____

Insured's employer:_____

B. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____Phone:_____

Address: _____

C. Emergency information: Who should I contact in an emergency?

Name: _____ Relationship: _____

Home/evening phone: _____ Cell phone:_____

D. Goal/Problem Information

Please briefly describe your reason for seeking psychotherapy at this time.

_____

_____

_____

_____

Have you ever sought therapy before? If so, how was it helpful?

_____

_____

What have you tried to help deal with your current problem? Has it been helpful?

_____

_____

_____

What are your goals for therapy? What would you like to see change?

_____

_____

_____

_____

_____

How would you know that you were done with therapy?

_____

_____

_____

Is there a history of mental health issues in your family? If yes, please list their relation to you and the issue.

_____

_____

Please indicate whether or not you have experienced any of the following symptoms in the past month. If yes, please provide some details in the space provided:

Suicidal or self-harm thoughts/impulses/actions	☐ No ☐ Yes	
Violent thoughts/impulses/actions	☐ No ☐ Yes	
Appetite problems	☐ No ☐ Yes	
Sleep problems	☐ No ☐ Yes	
Physical complaints/pain	☐ No ☐ Yes	
Anger/irritability	☐ No ☐ Yes	
Isolation/social withdrawal	☐ No ☐ Yes	
Anxiety/panic/phobias	☐ No ☐ Yes	
Depressed mood or loss of interest	☐ No ☐ Yes	
Binge eating and/or purging and/or food restriction	☐ No ☐ Yes	
Problems with drugs or alcohol	☐ No ☐ Yes	
Difficulty controlling impulses	☐ No ☐ Yes	
Strange or unusual behavior or experiences	☐ No ☐ Yes	
Confused or irrational thinking	☐ No ☐ Yes	
Bothersome, repetitive thoughts or behaviors	☐ No ☐ Yes	

Additional Comments: _____

E. Health and Medications

Do you have any current medical health issues?

_____

_____

Current Medications	**Dosage and Frequency**	**Prescribed by**	**Reason**

F. Other

What are your strengths?

_____

_____

Is there anything else important for me to know?

_____

_____

_____

_____