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OFFICE USE ONLY	
Payment	

NEW CLIENT INFORMATION

PERSONAL INFORMATION

Name____ Age________ Date___________

Address________________________ City_____________ State________ Zip_______

Phone_____________ Employer___________________ Referred By________________

Date of Birth___________ Requesting: ☐Individual ☐Couples ☐Group ☐Family

Religious Affiliation____________ Education_____________ SSN__________________

Email________________________________ Primary Concern_____________________

Emergency Contact __________________ Phone___________ Relationship_________

RELATIONSHIP STATUS

☐ Single ☐ Engaged ☐ Divorced
☐ Dating ☐ Married ☐ Widowed
☐ Living Together ☐ Separated

CHILDREN

Name________________________ DOB_______ Age___ Gender__ Marital Status___

Name________________________ DOB_______ Age___ Gender__ Marital Status___

Name________________________ DOB_______ Age___ Gender__ Marital Status___

Name________________________ DOB_______ Age___ Gender__ Marital Status___

PREVIOUS COUNSELING

Date________ Counselor________________________Reason_____________________

Date________ Counselor________________________Reason_____________________

Psychiatrist________________________Date_______ Reason_____________________

What do you hope to accomplish in our work together?____________________________

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PHYSICAL/MEDICAL INFORMATION

How would you rate your current health? ☐ Good ☐ Average ☐ Poor

Height__________ Weight__________ Recent Weight Changes?_______________

Are you currently taking prescribed or non-prescribed medications? Yes_____ No_____

List current medications and dosage____

____

Present or Past Significant Illnesses or Injuries?_________________________________

Physician's Name and Phone Number____

Recent losses, deaths of family/friends or significant life changes? Yes______ No_____

If yes, please explain____

Do you smoke?____How much?________Do you use alcohol?____How much?______

Self Care (Hobbies, Exercise)? ____

List some of your strengths____

List some of your limitations____

PRESENT CONCERNS (Mark any of the following you have experienced in the last three months)

BEHAVIORS	FEELINGS	PHYSICAL	THOUGHTS
☐ Explosive anger	☐ Numb Inside	☐ Always tired	☐ Suicidal thoughts
☐ Withdrawn	☐ Irritable	☐ Poor appetite	☐ Racing thoughts
☐ Indecisive	☐ Fearful	☐ Trouble Sleeping	☐ See things others don't
☐ More Impatient	☐ Inferior/Worthless	☐ Weight loss	☐ Always worried
☐ Don't like being alone	☐ Anxious/Nervous	☐ Weight gain	☐ Paranoid thoughts
☐ Difficulties at work	☐ Angry often	☐ Dizziness	☐ Nightmares
☐ Impulsive	☐ Like others are conspiring against me	☐ Shaky hands	☐ Worried about health
☐ Can't concentrate		☐ Stomach trouble	☐ No one understands me
☐ Easily excited	☐ Like smashing things	☐ Headaches	☐ Hear voices
☐ Relationships Difficulties	☐ Like hurting someone	☐ Fainting spells	☐ Flashbacks
☐ Restless	☐ Easily hurt	☐ Muscles twitches	☐ Out of body experience
☐ Full of energy	☐ Lonely	☐ Chest feels tight	☐ Obsessive thoughts
☐ Crying spells	☐ Not enjoying things	☐ Fast heartbeat	☐ Debilitating fears
☐ Unable to have fun	☐ Grieving	☐ Frequent sweating	☐ Confused easily
☐ Unable to pray	☐ Panicky	☐ Nausea/Vomiting	☐ Feels like I'm in a fog
☐ Unable to relax	☐ Low confidence	☐ Low energy	☐ Strange sexual urges
☐ Cutting/Self harm	☐ Guilty	☐ Sexual problems	☐ Like I'm being watched
☐ Compulsive behavior	☐ Depressed	☐ Joint/Back pain	☐ Loss of time
☐ Spend too much $$	☐ Hopeless	☐ Pain down arm(s)	☐ Other (Explain)

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