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# New Client Form

*ALL INFORMATION IS STRICTLY CONFIDENTIAL*

Today's Date:_____

Name: _____Date of Birth: _____Age_____

Address: _____

City/State/Zip:_____

Home Phone: _____Work Phone: _____

Mobile:_____

E-Mail: _____

Preferred Mode of Contact (circle all that apply):

Home Phone Work Phone Mobile Phone Text Email

Referred by: (Circle) Friend Website Family Professional

Insurance Other: _____

## Reason for Appointment

Information about…

Help in understanding…

Help in changing…

Learning how to…

Support in…

How satisfied would you say you are with your life overall right now? (Circle)
Not at all 1 2 3 4 5 6 7 8 9 10 Completely

## Symptoms

Please circle the following symptoms you ***are currently OR have ever*** experienced:

| | | | |
|---|---|---|---|
| mood swings | problem relationship | sexual abuse | problem hearing |
| problem sleeping | family issues | self-harm | vision problem |
| anxiety | work issues | witness to violence | loss/grief |
| depression | legal issues | head injury | compulsions |
| anger | emotional abuse | drinking too much | disability |
| ear/other infectons | obsessions | drug/opoid abuse | seizures |
| smoking daily | miscarriage | addiction | headaches |
| low self-esteem | abortion | obssessing | asthma |
| sexual issues | chronic pain/illness | physical abuse | trauma |
| hyperactivity | hospitalization | self-sabotage | sexual abuse |
| panic attacks | isolation | major accident | appetite issues |

## History

Have you sought mental health treatment before? Yes No
If yes, please list prior counseling/therapy (name, year, # of sessions):

Prior mental health diagnosis if applicable:

List current medications and other vitamins, aspirin, etc.with dose/frequence of use/prescriber if applicable (use other side of page for additional space)

1. _____
2. _____
3. _____

Have you ever had suicidal thoughts/feelings and/or attempts or engaged in any self-harming behaviors? _____(Please go back and circle all the underlined words that apply).
If yes, on a scale of 1-10 (*1 being neutral/not at all, 10 being extreme*) how high has it (suicidal feelings or compulsions to self harm) gotten in the past year? ____ How high would you say it is now?____

Have you ever binged, purged, or restricted your food intake? Yes No
Have you ever been convicted of a crime? Yes No

# More About You:

*Relationship/Marital Status:* (Cirlce)

Single Married Partnered Living together Divorced

*Number of Children*:___ Ages: _____

*Number of Siblings*: ____ Ages: _____

*Occupation/Employer*: _____
*Living Situation:* _____

*Physical Activity:* (Circle)

None Minimal Moderate 3x/week or more Type: _____

*Social Activity/Support*: (Circle)

None Minimal Moderate 3x/week or more Type: _____

*Sexual/partner orientation:* (Circle)

Heterosexual Homosexual Lesbian Bisexual Pansexual Unsure

Monogomous Non-Monogomous Unsure

*Currently in a relationship*: Yes No

*Brief statement on your spiritual/religious beliefs*:

*Are you willing to complete therapy-related assigments between sessions?* (Cirlce)
Yes No Unsure

*Are you willing to complete feedback forms on quality of sessions/effectiveness of treatment if requested?* Yes No Unsure