New Client Information Form

Legal Name ____ Date ____________________

What do you prefer to be called? ____

Date of Birth __________________ Age ______ Place of Birth __________________________

Home Phone ____________________________ Okay to leave a message at this #? YES NO

Cell Phone _____________________________ Okay to leave a message at this #? YES NO

Email ____ Okay to leave a message? ______

Would you like to receive reminder texts or emails for your appointments? Check YES NO

Initial next to the way you would like to receive reminders: _____ TEXT or _____ EMAIL (select one)*

* By initialing this, you are agreeing to any limitations of confidentiality inherent in the use of these technologies.

If I cannot leave voicemails/emails at any of the above numbers, how can I reach you while protecting your confidentiality? ____

Home Address ____

Emergency Contact Person______________________________ Relationship _____________________

Emergency Contact Number ____________________________

As you work through these questions, please be gentle with yourself, and have permission to not go into detail on anything that feels overwhelming. We will have lots of time to deepen into things later.

Please state briefly your reasons for seeking therapy *at this time*:

How long have these problems persisted?

Culture & Self *Please describe yourself as fully as you feel comfortable.*

How would you describe your gender? ____
(e.g., male, female, transgender (MTF, FTM), intersex, gender-queer, etc.)

What would you like me to know about your racial and ethnic heritage, and how it impacts you in the past or present? ____

____

How would you describe your sexual orientation? ____
(e.g., gay, lesbian, heterosexual, bisexual, questioning, queer, etc.)

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What was your religious/spiritual upbringing? ____

What is your current religious or spiritual orientation and interest? ________________________________

____

Family

What is your relationship status?

- ☐ Single
- ☐ Married/Partnered
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Dating
- ☐ Other (please specify): __________
- ☐ _________________

Name of partner: _____________________________________ Supportive of your therapy? _________

If you have children, please list their names, ages, and brief description of your relationship with them:

____

____

____

____

Do you have any pets? ____

What, if anything, do you know about the circumstances surrounding your conception, time in utero, and birth?

____

____

From infancy to ages 12/13, how would you describe your childhood and family, growing up?

____

____

____

____

What were your teen years like? ____

____

____

____

Tell me about your childhood friends and social scene … ____

____

____

____

Do you have any siblings? Please list names, ages relative to you, and a brief description of your relationship with them: ____

____

____

____

What was your parents' relationship like, throughout your time living at home? __________________

Who else, besides your parents, was a caring person in your life while you were growing up?

Do any of your family members have a history of, or current problems with:

- ☐ Mental Health issues ______
- ☐ Alcohol or drug use ______
- ☐ Violence ______
- ☐ Suicide ______

Social Functioning & Self-Care

What do you like to do for self-care? ______

How often do you exercise/get active & what kinds of activities do you do? ______

Who are your social supports? Who are your emotional supports? ______

What are your hobbies & interests? ______

What is going well in your life at this time? ______

Education & Training

Highest level of schooling/training ______

Name/location of most recent or current school ______

Areas of study/training ______

Plans / dreams to learn about...______

Work & Employment

Check all that apply:

- ❏ Full Time
- ❏ Part Time
- ❏ Retired
- ❏ Student
- ❏ Unemployed
- ❏ Parent/Caregiver

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Occupation ____________________________ How much do you enjoy your work? _______________

Place(s) of employment____

What would be your dream job/career? ____

Mental Health History & Suicide Risk

Have you been in psychotherapy before? __ Yes __ No If yes, how long and for what reason(s)?

____

____

Have you been hospitalized for mental health reasons? If yes, please describe. ____________________

____

Have you ever considered suicide? __ Yes __ No Did you have a plan? __ Yes __ No

Have you ever attempted suicide? __ Yes __ No if yes, date/s: _____________________

Do you currently feel suicidal? __ Yes __ No

Have you experienced urges or engaged in other acts of self harm (e.g. cutting) __Current __Past __No

Physical Health & Medical History

Do you have any physical health concerns I should know about? _________________________________

____

Any past medical issues/injuries? ____

____

Do you have any allergies? __ Yes __ No If yes, what types? ______________________________

Do you have a disability? __ Yes __ No Please specify if 'yes': ___________________________________

Please check any of the following health issues that you are currently experiencing:

- ❏ High Blood Pressure
- ❏ Low Blood Pressure
- ❏ Heart Issues
- ❏ Autoimmune Disease
- ❏ Respiratory Issues
- ❏ GI/Stomach/Digestion Issues
- ❏ Unexplained Chronic Pain
- ❏ Other: _______________________
- ❏ Other: _______________________

Details of any of the above you would like me to know? _____________________________________

____

____

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Current medications? *(please list medications, dosage, reason, how each is helpful, and any negative side effects)*

Medication	Reason	Dosage	How is it helpful?	Negative side effects?

Trauma History

Have you ever experienced any of the following (please check all that apply):

- ❑ Physical abuse
- ❑ Emotional/Psychological abuse
- ❑ Sexual abuse
- ❑ Spiritual abuse
- ❑ Violence/War
- ❑ Physical assault/violence
- ❑ Sexual assault/Rape
- ❑ Neglect
- ❑ Domestic Violence
- ❑ Witness to any of the above
- ❑ Work-Related Trauma
- ❑ Compassion Fatigue
- ❑ Natural Disasters
- ❑ Other

For anything that you checked, what would you like me to know about it for now? ___________________

____

____

____

How, if at all, do you feel like these experiences affect you currently? ______________________________

____

____

What significant losses have you had in your life? ____

____

____

What, if anything, do you know about trauma and loss in your family history? _____________________

____

____

____

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Substance Use

Is your use of alcohol, marijuana, or any other substance an area of concern for you at this time?

__ Yes __ No Please describe your use of the following:

	Times/week	Amount/Method of use
Alcohol		
Tobacco		
Marijuana		
Other Substances (list type)		
Caffeine		

Have you ever been treated for substance abuse or other addictive behavior? __Yes __ No

If yes, please describe the nature of the addiction, and the location & dates of treatment:

____

____

Within the past two years:

Have you experienced black-outs or lost time due to substance use? Yes No

Have you noticed you have to use more to get the same effect? Yes No

Have you had any drug or alcohol related medical problems? Yes No

Has your use caused you problems at work or school? Yes No

Have you used more than you intended to? Yes No

Have friends or family complained about your use and its effect on them? Yes No

Present Moment Living & Daily Functioning

How is your sleep? ____

How are your appetite and eating patterns? ____

____

Please rate your level of stress from 1-10 (1 being lowest, 10 highest): ________________________

In the past year, have you experienced any of the following? (please check all that apply):

☐ Depressed mood ☐ Feeling isolated or withdrawn

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- ☐ Feeling floaty or detached
- ☐ Feeling hopeless
- ☐ Low energy/fatigue
- ☐ Intense anger or rage
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Loss of interest in things you used to enjoy
- ☐ Feelings of worthlessness
- ☐ Difficulty concentrating
- ☐ Ruminating/racing thoughts
- ☐ Out of control or grandiose moods
- ☐ Change in sleep patterns
- ☐ Impulsive behaviors
- ☐ hyperactivity
- ☐ Feeling anxious or nervous
- ☐ Panic attacks
- ☐ Excessive worry that is difficult to control
- ☐ "irrational" fears
- ☐ Disturbing memories, nightmares, or intrusive thoughts
- ☐ Feeling on edge/hypervigilent
- ☐ Easily startled
- ☐ Seeing or hearing things that aren't really there
- ☐ Binge eating
- ☐ Restricting food intake
- ☐ Purging (self-induced vomiting, use of laxatives, use of exercise)
- ☐ Compulsive behaviors
- ☐ Obsessive thoughts

For all that you checked, how are these symptoms affecting you?

- ☐ Family functioning ____
- ☐ Socially _______ ____
- ☐ At work/school ____
- ☐ Spiritually ____
- ☐ In intimate relationships ____
- ☐ Other ____

Anything else that you would like me to know at this time? ______________________________
____

What are your hopes, in coming to counseling? What would you like to get out of our time together?
____
____
____
____

What might you already be doing towards that end? ______________________________
____

______________________________________ ______________

Client Signature **Date**

** to sign and submit electronically, type */s/Your Name* in the signature field. Example: */s/Jane Doe*