NEW CLIENT INFORMATION

Date: ________________________

Client's Name: ____

If client is a Minor:

Parents Legal Guardian
Name:____

Are Parent's currently married and living together or divorced?
____

Client's Date of Birth: ____

Client's Address: ____

Home Phone: __________________________ Work Phone: ___________________________

Cell Phone: ____________________________ Email Address: __________________________

Is it okay to leave messages at the above phone numbers or emails address for correspondence related to therapy services, appointments, or billing? (Please specify which numbers or email address you would like me to leave messages on.

Single _____ Married _____ Domestic Partnership _______ Divorced _______ Other _____

Spouse/Partners Name: ____

Name/Age of
Children/Siblings____

____

Client's employer/School: _________________________ Occupation: ____________________

Primary Care Physician: __________________________ Phone #: _______________________

Current Medications: ____

Person to Notify in the event of an emergency: ____

Relationship: ____

Home phone: _______________ Work phone: ______________ Cell phone: __________________

Address: ____

Have you received previous counseling or psychological care? _____________ If so, by whom, and when?

____

Are you currently experiencing overwhelming sadness, grief or depression? _________________

If, yes, for how long ____

Are you currently experiencing anxiety, panic attacks or have any phobias? _________________

If yes, when did you begin experiencing this? ____

What significant or stressful events have you experienced recently?

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Please add any other information you think might be helpful including the reason for coming, family history of mental disorders or medical problems.

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How did you hear about this practice?

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