Insight Guidance

5049 Swamp Rd, Suite 305, Doylestown, PA 18923

New Client Information Form

Please answer the questions below. The information you provide here is protected as confidential information. Please bring the completed form to your first session.

Name: _____(First) (Middle Initial) (Last)

Birth Date: _____ /_____ /_____ Age: _____ Pronouns: _____

Romantic Relationship Status (circle all that apply):

Single Dating In a Relationship Married Separated Divorced Widowed

Please list any children/age(s): _____

Address: _____

_____

Cell Phone: ( ) _____May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Current Primary Care Doctor: _____ Phone:_____

Have you previously received any type of mental health services (psychotherapy, counseling, psychiatric, services, etc.)? □ No □ Yes, previous therapist/practitioner:
_____

Dates of services:_____

Are you currently taking any prescription medication? □ Yes □ No Please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No Please list and provide dates: _____
_____

Medication Allergies: □ Yes □ No Please list: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. Please list any active and/or chronic medical conditions/diagnosis: _____

_____

4. Please list all current medications, including vitamins and supplements you are taking: (Medication Name, Dose (e.g. 2 mg) and Frequency (e.g. 2x daily)

_____

_____

5. How many times per week do you generally exercise? _____ What types of exercise do you participate in? _____

6. Please list any difficulties you experience with your appetite or eating patterns:
_____

7. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes If yes, for approximately how long? _____

8. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:
_____

10. Do you drink alcohol more than once a week? □ No □ Yes
If yes, how many days per week: _____ How many glasses per day? _____

11. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

12. Do you smoke/vape? □ No □ Yes If yes, how many per day? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY: In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sister, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/ no/ don't know	
Anxiety	yes /no/ don't know	
Depression	yes/ no/ don't know	
Domestic Violence	yes/ no/ don't know	
Eating Disorders	yes/ no/ don't know	
Obsessive Compulsive Behavior	yes/ no/ don't know	
Schizophrenia	yes/ no/ don't know	
Suicide Attempts	yes/ no/ don't know	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Is there currently any Children and Youth Involvement? □ No □ Yes

3. Are there currently any legal issues or justice system involvement? □ No □ Yes

4. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

5. What do you consider to be some of your strengths?

_____

_____

_____

_____

6. What do you consider to be some of your areas for growth?

_____

_____

_____

_____

7. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____

8. Is there anything else you think is important for your therapist to know?

_____

_____

Client Signature:_____ Date: _____

Emergency Contact Information

Name: _____

Address: _____

Relationship: _____

Cell Phone: _____ Home Phone: _____

Email address: _____

Please note: HIPAA regulations require strict confidentiality except for cases of imminent threat or danger to or from the client. Listed below are the guidelines in which it is permitted for a therapist to contact the family member or designated emergency contact. All other information remains confidential unless the client completes the appropriate authorization for release of information form.

1. Given that the patient is no longer present, if the therapist determines, based on professional judgment, that there may be an emergency situation and that contacting the family member of the absent patient is in the patient's best interests; or
2. If the disclosure is needed to lessen a serious and imminent threat and the family member is in a position to avert or lessen the threat.