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)

Name of parent/guardian (if under 18 years):
____(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	

SCHOOL INFORMATION: (If not in school, write N/A)

Current Grade: ________________ School Name: ________________________________

Concerns with School: ____

Do you have, or ever had, a 504 or IEP? _______________________________________

ADDITIONAL INFORMATION:

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

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.