NEW CLIENT QUESTIONNAIRE (ADULTS)

Date:____ / _____ / _____.

Patient Information:		
Last Name: DOB:	First Name:	Middle Name: SS#
Address:	City:	Gender: M F Religion:
State:	Zip Code:	Marital Status Ethnicity:

Contact Information:

Home Phone: _____ Can we leave a message at this number? YES NO
Work Phone: _____ Can we leave a message at this number? YES NO
Cell Phone: _____ Can we leave a message at this number? YES NO
Email: _____ May we contact you by Email? YES NO
How you prefer to be contacted? _____

Insurance Information:

Insurance Carrier: _____ ID # _____

Insurance Holder Name: _____ Relation: _____

Group: _____ Insurance Holder DOB: _____

Emergency Contact Information:

Emergency Contact: _____ Phone # _____

Relationship: _____

General Information:

Allergies:_____

Pharmacy: _____

Presenting Concerns:

What brings you in for services?

Medical Information:

Primary Care Physician:_____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

PAST MEDICAL HISTORY:
Please mark any current or past experiences with the following:

Anemia	Problems with Vision	Congestive Heart Failure
Atrial Fibrilation	Hearing Difficulties	Inflammatory Bowel
Asthma	Numbness / Tingling	Syndrome
HIV / AIDS	Head Injuries	Weight Gain
Shortness of breath	Stomach Ulcer	Irritable bowel Syndrome
COPD	Nausea / Vomiting	Weight Loss
Chronic Pain	Cancer	Sleep Difficulties
Chronic cough	Heartburn / Reflux	Diabetes
Skin Problems	Stroke	Jaundice
Glaucoma	Chronic Lung Disease	Kidney / Bladder problems
Sickle Cell	Hernia	Diverticulosis
Fatigue	Thyroid Disease	Pacemaker
Heart Attack	Colon Polyps	Emphysema
Seizures	Headaches	Pancreatitis
Sexual Disfunction	High Blood Pressure	Liver Disease
Transfusions	Other: _____	_____
_____	_____	_____

PAST SURGICAL HISTORY: Please identify any significant surgeries.

_____
_____
_____
_____

Current Medications:

Medication	Dosage / Frequency	Condition	Prescribing Physician

PREVIOUS BEHAVIORAL HEALTH SERVICES:

(Such as with a Psychologist, Social Worker, Psychiatrist, Counselor or Psychological testing).

With Whom	When	Type of treatment	Were you hospitalized? Where?

CURRENT LIVING SITUATION: Who is currently living with you?

Person	Age	Relationship