M Kelly Ward Therapy Services

M Kelly Ward MA LPC

New Client Form (Adult) Date _____________

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name:____ **Gender:**________ **Age:** ______ **DOB:** _____________

Spouse/Significant other: ________________________________ **Relationship:** __________________________

Address ____________________________ **City:** ____________________ **State:** _____ **Zip code:** _________

Home Phone: ___________________ **Work Phone:** ___________________ **Cell:** _______________________

Email address: ________________________ **May we contact you via: Home Phone Cell Phone Work Phone**

Email (email is non-secure) **Other:**__________________________________

May we leave a Voice Message? YES NO

Other Emergency Contact:________________________ **Relationship:** _____________ **Phone:** _______________

Place of Birth: ________________________ **Ethnic/Cultural Background:**___________**Religion:**______________

Native Language: _____________ **School:** __________________________________

Grade:________________

Occupation: ___________________________ **Employer:** _______________________

Referred by: __________________________ **May I thank this referral source for directing you to this practice? Yes No**

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services:

- **Has anything happened that may have brought on/intensified your problems? Yes No**

If yes, please explain"____
____

- **When (month/year) did you first begin to experience these problems?** _________________________

- **How many days, weeks, months, or years have you been experiencing these problems?**

  ____

- **How often do you experience these problems? (check the one that best describes your current experience).**
  - ❑ **Most of the day, every day**
  - ❑ **Some part of the day, every day**
  - ❑ **Most of the day on most days**
  - ❑ **Some part of the day on most days**
  - ❑ **More than once a week**
  - ❑ **More than once a month**
- **How much is/are the problems affecting you?** **Mildly** **Moderately** **Severely**

- **In what areas do your problems impact your life? (Check all that apply)**

  Lifestyle (the way you live your life)

  Activities (things you normally do or would like to do)

  Relationships (your ability to form or maintain relationships with others)

  Eating

  Sleeping

  Mood

- **Have you ever attempted suicide? Yes No** **If yes, when? ________________**
- **Have you been thinking about suicide? Yes No**
- **Have you ever thought about harming or killing someone else? Yes No** **If yes, when? _______________**

  Have you been thinking about harming or killing someone else? Yes No

Problems Checklist: Check all that apply

- ❑ Depression
- ❑ Low energy
- ❑ Low self-esteem
- ❑ Poor concentration
- ❑ Lack of interest/enjoyment in life
- ❑ Feeling hopeless
- ❑ Feeling worthless
- ❑ Feeling guilty or shameful
- ❑ Sleep changes (more/less)
- ❑ Loneliness
- ❑ Bad dreams/nightmares
- ❑ Feeling Ignored or abandoned
- ❑ Appetite changes (more/less)
- ❑ Mood swings
- ❑ Thoughts of hurting self
- ❑ Thoughts of hurting others
- ❑ Isolating from others/social withdrawal
- ❑ Feelings of sadness/loss
- ❑ Weight problems
- ❑ Stress
- ❑ Anxiety/tension/worry
- ❑ Panic attacks
- ❑ Heart racing
- ❑ Chest pain or heaviness
- ❑ Chills/hot flashes
- ❑ Tingling/numbness
- ❑ Pain
- ❑ Fear of dying
- ❑ Fear of going “crazy”
- ❑ Nausea
- ❑ Fears or phobias
- ❑ Obsessions/compulsions
- ❑ Thoughts racing
- ❑ Disorganization
- ❑ Procrastination
- ❑ Can’t hold onto an idea
- ❑ Anger/frustration
- ❑ Suspiciousness or mistrustfulness
- ❑ Problems trusting others
- ❑ Easily irritated/annoyed
- ❑ Aggressiveness
- ❑ Perfectionist behavior

- ❑ Lying
- ❑ Making/keeping friends
- ❑ Arguing with others
- ❑ Performing unusual rituals or habits
- ❑ Impulsiveness
- ❑ Excessive behaviors (Examples: spending, gambling)
- ❑ Delusions/hallucinations (Thinking/believing or seeing/hearing unusual things)
- ❑ Sexual problems/behavior
- ❑ Self injurious behaviors
- ❑ Shyness
- ❑ Social skills
- ❑ Social support (family/friends)
- ❑ Stealing
- ❑ Strange, weird, or peculiar behavior
- ❑ Confusion/can't think clearly
- ❑ Feeling "not real"
- ❑ Feeling detached from yourself
- ❑ Feeling "hyper"
- ❑ Financial problems
- ❑ Grief/bereavement
- ❑ Health problems
- ❑ Impact of your problems on others
- ❑ Losing track of time
- ❑ Problems with memory
- ❑ Unpleasant thoughts that won't go away
- ❑ Bothered by recurring thoughts
- ❑ school/educational problems or indecision
- ❑ Destruction of property
- ❑ Self-criticism
- ❑ Family problems
- ❑ Marital/relationship problems
- ❑ Parent/child problems
- ❑ Use of alcohol
- ❑ Use of drugs
- ❑ Blackouts
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Partner abuse
- ❑ Trouble with the law
- ❑ Experienced/witnessed trauma
- ❑ Loss/death of someone close
- ❑ Impulsive behaviors
- ❑ Other (please describe)

Additional Information

Use this page if there is additional information you would like to share with the therapist.