NEW CLIENT INFORMATION

Please provide the following information and answer the questions below. Please note, information you provide here is protected as confidential information. You may print this form and bring it with you to our initial session.

Today's Date: _____

GENERAL INFORMATION

Name: _____

(Last) (First) (Middle Initial)

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

_____

(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age: _____ Gender [ ] Male [ ] Female [ ] Other

Address:

_____

_____ Zip Code_____

Insurance Carrier: _____

Member ID: _____ Group Number:_____

Do you know your co-pay amount? Yes No Amount $_____ (Co-pay is required at time of service)

Please note, it is your responsibility to contact your insurance provider regarding deductible and copay amounts prior to our initial visit. Your customer service number is typically on the back of your insurance card.

Contact Information:

Home Phone: Mobile: Please circle contact preference

May I leave a message? Yes No

Do you prefer text messages? Yes No

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Education

High School:

_____

(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education:

Explain:

_____

_____

Is or was school performance a concern for you?

If yes, explain:

_____

_____

Marital/Relationship Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Comitted Relationship

On a scale of 1-10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced

recently?_____

_____

_____

Additional Family Information

Children: Yes No

Do you have brothers or sisters?

Who currently lives in your household?

Describe your relationship with:

Parents:

_____

Siblings:

_____

Extended Family Members:

_____

Husband/Wife/Significant Other:

_____

Your Children:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Primary Care Physician: _____ Phone: _____

PCP Address: _____

Chronic Medical Conditions: _____

_____

Are you currently taking any prescription medications? Yes No

Please List: _____

_____

Please List
Allergies_____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Psychiatric History

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, Inpatient treatment, ECT.)? Yes_____ No_____

If yes, when and where?

_____

_____

_____

Have you ever been prescribed psychiatric medication? Yes No

Prescribing Provider: _____ Phone:_____

Please List All Psychiatric Medications:

_____

_____

_____

Please list any specific psychiatric problems you are currently experiencing (anxiety, panic attacks. depression, suicidal thoughts, etc.):

_____

_____

How long has this been a concern? _____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

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

_____

_____

Are any physical characteristics or body image a concern? Explain:

_____

_____

Is sexual functioning an area of concern for you? Explain:

_____

_____

Substance Use

Do you drink alcohol? Yes_____ No_____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use?

Daily____ Weekly____ Monthly _____ Never____

Is recreational drug use an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

Trauma History

Have you experienced physical, sexual or emotional abuse or other trauma? Yes___ No___

If yes,
explain_____

_____

_____

Have you ever received treatment for these issues including EMDR (Eye Movement Desensitization and Reprocessing) YES NO

If yes, when and with whom? _____

Family Mental Health History

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

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Bipolar Disorder yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Post -Traumatic Stress Disorder (PTSD)

Schizophrenia yes/no

Suicide Attempts yes/no

Additional Information: _____

_____

Legal History

Do you have a history of any legal charges? Yes_____ No

Please Explain:_____

Are you currently on probation or parole? Yes_____ No_____

Employment

Are you currently employed? Yes____ No_____

If yes, what is your current employment situation?

_____

_____

Additional Information

What do you consider to be some of your strengths?

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

Is there anything else you would like to be addressed in our initial session?

_____

_____

My fees, cancellation policy, HIPAA policies and your rights as a client will be provided for review at our initial visit or have been sent to you via e-mail for review. Please note, if after this assessment I do not feel I am able to provide the appropriate clinical services and level of care necessary, we will discuss additional referral options.

_____ _____

Signature of client **Date**