MINDING YOU

DUI Services | Mental Health | Addiction Recovery | Evaluations

Stephanie Higdon LCSW, CAADC

New Client Information Sheet

Age: _____ Birth date: _____ Client Record #: _____ Cash: _____ Insurance: _____

Insurance Company: _____ Co-Pay: _____

Client's Legal Name: _____
Last First

How did you find out about Minding You? _____

Is there a pending litigation? _____Yes _____No

Cell Phone # _____ Home / Other Phone # _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse/Partner's Name (If applicable): _____ Age: _____

Length of Relationship: _____ Date of last divorce (if applicable): _____

Children (gender, age): _____

Your highest level of education completed: _____

Current Occupation: _____ # Hours worked/week: _____

Do you practice a religion? ___Yes ___No If yes, what is your faith? _____

Homicidal / suicidal thoughts currently? ___Yes ___No History of thoughts? _____Yes _____No

Do you have a history of self- harming? ___Yes ___No Have you ever attempted suicide? _____Yes _____No

Have you had previous counseling or psychotherapy? ___Yes ___No

Have you ever been hospitalized for psychological /mental problems? ___Yes ___No

If so, please explain:

_____

_____

Please indicate any of the following symptoms you have experienced in the past three months:

_____ Increased appetite
_____ Decreased appetite
_____ Trouble Concentrating
_____ Difficulty Sleeping
_____ Excessive Sleep
_____ Low Motivation
_____ Isolation from others
_____ Fatigue/ low energy
_____ Low self-esteem
_____ Depressed Mood
_____ Tearful or crying spells
_____ Hopelessness
_____ Loss of interest in activities
_____ Anxiety
_____ Fear
_____ Panic

Other:_____
_____

**Any symptoms or issues checked above will be discussed further with a counselor through course of intake*

What has brought you to counseling? What is the nature of the concern (s) you wish to address in counseling?

_____

_____

What are you hoping to achieve from counseling?

_____

_____

What are some of your short and long-term goals?

_____

_____

_____

In Case of Emergency, who should be notified?

Name: _____ Phone: _____

Relationship: _____

I certify that the above information is true to the best of my knowledge.

_____ _____

Client/ Parent or Guardian Signature Date

_____ _____

Minding You Therapist Date:
Stephanie Higdon, LCSW, CAADC