NEW CLIENT INFORMATION

Today's Date: _____

Client's Name: _____

Client Identification Number: _____

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Full Name:_____ Social Security Number: _____

DOB: _____ Age: _____ Gender: _____

Parent/Legal Guardian (if under 18): _____

Insurance ID or Group No.: _____ Insurance Co.: _____

In Case of Emergency, Contact:

Name: _____ Relationship to client: _____

Day Phone: _____ Evening Phone: _____

Client Information:

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication. As a result, Healing and Wellness Counseling, LLC's policy is to use email *only* for appointment reminders.

Who may I thank for referring you to me? _____

What would you like to accomplish out of your time in therapy? _____

_____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

WORK AND FAMILY

Are you currently employed? □ No □ Yes

If yes, who is your current employer? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

School: _____ Highest Grade Completed: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

How would you describe your relationship?_____

_____

_____

Please list everyone living in the client's home:

NAME	AGE	GENDER	RELATIONSHIP

Does the client have children who are not living in the home? □ No □ Yes

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 (e.g. father, grandmother, uncle, etc.)

Please Circle yes or no and List Family Member

Alcohol/Substance Abuse □ No □ Yes _____

Anxiety □ No □ Yes _____

Depression □ No □ Yes _____

Domestic Violence □ No □ Yes _____

Eating Disorders □ No □ Yes _____

Obesity □ No □ Yes _____

Obsessive Compulsive Behavior □ No □ Yes _____

Schizophrenia □ No □ Yes _____

Suicide Attempts □ No □ Yes _____

SPIRITUALITY

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

_____

What do you consider to be some of your strengths? _____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

MENTAL HEALTH HISTORY

Check if you have received any of the following services and explain below:

□ Psychiatric or psychological evaluation
□ No mental health services whatsoever
□ Drug or alcohol evaluation
□ Counseling or psychotherapy (outpatient)
□ Evaluation or treatment for gambling
□ Drug or alcohol treatment
□ Evaluation, treatment or class for anger control
□ Psychiatric hospitalization
□ Employee Assistance Program (EAP) counseling
□ Marital/family counseling

If you have previously received outpatient or inpatient mental health services (psychotherapy, psychiatric services, etc), please complete the following chart:

DATES	NAME OF PROVIDER/HOSPITAL	REASON

Are you currently taking any prescription medication? □ No □ Yes
If yes, complete the following chart:

NAME OF MEDICATION	DOSE & FREQUENCY	REASON	PRESCRIBING PHYSICIAN

Have you ever been prescribed psychiatric medication in the past? □ No □ Yes
If yes, please complete the following chart:

NAME OF MEDICATION	DATES TAKEN	REASON FOR TAKING	REASON STOPPED

PHYSICAL

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific physical health problems you are currently experiencing: _____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

SUBSTANCE USE

Do you drink alcohol more than once a week? □ No □ Yes Do you use nicotine? □ No □ Yes

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

FINANCIAL

Briefly describe any financial difficulties you are experiencing here:

_____

_____

_____

LEGAL

Briefly describe any legal difficulties you are experiencing here: _____

_____

_____

CURRENT PROBLEM CHECKLIST - ADULT

Because people experience a wide range of difficulties, the checklist covers many possible problems. Although many of them may not apply to you, please take your time in completing the checklist. This information is very valuable in helping your counselor provide better service to you.

During the past month if you have experienced a problem, circle the "Y." If you have not had the problem during the past month, circle "N."

Y N Lack of energy...easily tired, fatigued/physically tired often
Y N Poor concentration/memory ...can't pay attention/easily distracted/mind goes blank/can't remember
Y N Cannot make decisions...can't figure out what to do as well as I could before
Y N Loss of interest...don't care about things like I used to
(continued on next page)
Y N Feeling depressed ...feeling blue/low/or down much of the time **If yes, for how long?_____**

Y N Hopelessness ...things just will not work out right in the future/trapped
Y N Crying episodes ...crying easily/wrong time/can't stop crying at times•
Y N Poor appetite...don't eat enough/don't want to eat
Y N Sleep problems...difficulty going to sleep or staying asleep/nightmares/difficulty in waking up **If yes, please specify: _____**

Y N Suicidal thoughts ...wanting to die/sometimes would rather be dead than alive
Y N Angry or irritable ...feel like I want to hurt someone/smash, break things/easily upset/touchy
Y N Restless...can't sit still for long
Y N Periods of feeling lots of energy...hyper /driven/elated/giddy/can accomplish anything
Y N Quick to argue...unusually irritable for days at a time/wanting to fight
Y N Difficulty controlling my actions...acting too quickly/not thinking things through
Y N Tense or anxious...too worried or keyed up about various things
Y N Fear of failure...at school, work/feel unable to succeed
Y N Panic episodes ...become terrified/overwhelmed/very frightened **If yes, when did you begin experiencing this? _____**

Y N Intruding thoughts ...can't stop thinking about something or someone
Y N Repeated actions ...need to keep checking on something/need things to be in order
Y N Having experienced or witnessed an event involving actual or threatened death/serious injury
Y N Experiencing recurrent distressing or unwanted dreams/images/thoughts/perceptions
Y N Every day worrying about gaining weight or becoming fat/family or friends commented about weight loss
Y N Vomited or felt the urge to vomit after eating too much
Y N Have used laxatives more than once in the past month
Y N Physically injured yourself on purpose or otherwise tried to harm yourself
Y N Feeling inferior or easily hurt...others seem unfriendly/don't understand me
Y N Feeling fearful or suspiciousness ...fear something bad will happen/can't trust others/need to be on guard
Y N Loss of control...feel like someone, something is controlling my mind
Y N Needing to be punished...feel like my sins are unpardonable
Y N Distortions...seeing, hearing, feeling things that are not real
Y N Self-conscious...with others/very uncomfortable when people watch me
Y N Loneliness...feeling like no one cares about me

Y N Feelings of regret...ashamed/guilty/feel like a "bad" person
Y N Bad habits...keep doing things that could cause a serious problem
Y N Unrealistic fears ...afraid of things or people I know won't hurt me
Y N Chronic pain...headaches/stomach problems/beck pain or other physical problems **If yes, please describe: _____**

Y N Heart problems...pounding/skipping beats/painful/racing
Y N Hot - cold flashes ...sweating/chills not related to air temperature
(continued on next page)
Y N Dizziness/tingling/numbness ...fainting/fear of falling over/things spinning
Y N Sexual problems...having feelings or actions not as they should be/having "bad" habits
Y N Have you ever felt you should cut down on your drinking or drug use?
Y N Have other people annoyed you by criticizing your drinking or drug use?
Y N Have you ever felt guilt about your drinking or drug use?
Y N Have you ever taken a drink in the morning to steady your nerves or get rid of a hangover?

If the client is a minor child, a biological parent or legal guardian must complete this section!

If the child's parents are divorced, to which parent has the court given custody?

□ Mother □ Father □ Joint □ Other _____

Your Name: _____ DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Marital Status: _____ Social Security Number: _____

Your Relationship to client: _____

If applicable, please list name and contact information for the non-custodial parent _____

_____

_____

If applicable, please list name and contact information for child's caseworker: _____

_____

_____

Thank you!