For New Clients

20191001 version

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Today's Date: _____

Name: _____

Date of Birth: _____

Gender: _____ Male _____ Female

Home phone: _____ Cell _____ Work _____

May I contact you and leave messages at these phone numbers? _____Yes _____No

Address: _____

City: _____ State: _____ Zip: _____

May I send mail to this physical address? _____Yes _____No

Email: _____

May I email you? _____Yes _____No

Education (check all that are applicable):

_____ high school diploma _____ GED
_____ some college _____ 1, 2, or 3 year degree
_____ 4 year degree _____ graduate degree

How would you describe yourself as a student? _____

Work school status: _____ employed _____ unemployed _____ student
_____ homemaker _____ retired _____ disabled

Employer: _____

Job title: _____

What do you do there? _____

How long have you worked there? _____ How long in this occupation? _____

General comments about education and career history

_____

Cultural orientation: _____

Religion or spiritual perspective: _____

Relationships:

Current Relationship Status:

_____ Single _____ In a relationship _____ Engaged _____ Married
_____ In a civil union _____ In a domestic partnership _____ In an open relationship
_____ It's complicated _____ Separated _____ Divorced _____ Widowed
_____ Other – describe …

_____

Current partner's name if applicable: _____

Names of children, if any: _____

_____

_____

_____

_____

_____

Current living arrangements: _____

Names of others in your household, if any: _____

_____

_____

_____

_____

Primary care physician: _____ Phone: _____

Address: _____

List any significant health problems: _____

_____

List any medications you are presently taking and the dosage: _____

Who referred you or how did you learn about us?

_____

Is there a possibility my case might involve court proceedings? _____Yes _____ No

If so, describe: _____

_____

Emergency Contact Information:

Name: _____ Relationship to client: _____

Phone: (if different from above) _____

Address: (if different from above) _____

Financially Responsible Person's Information:

Name: _____ Relationship to client: _____

Phone: (if different from above) _____

Address: (if different from above) _____

Insurance:

Carrier _____

Insurance ID# _____

Group ID# _____

Insurance Company Phone# _____

Therapeutic Information:

What issue(s) bring you in for a therapeutic consultation? _____

_____

_____

_____

_____

_____

How long have the situation(s) existed? _____

Have you consulted with other professionals regarding this matter? _____

If yes, when and with whom? _____

What is important for the therapeutic process about the history of this issue or these issues?

_____

_____

_____

_____

_____

Have you consulted with a psychotherapist for any other reason before? _____ Yes _____ No

If yes, when, with whom, and for what? _____

_____

_____

_____

_____

Have you ever experienced any domestic violence or abuse? _____ Yes _____ No

If so, what kinds and during what part of your life? _____

_____

_____

_____

_____

Have you ever experienced or are you currently experiencing suicidal thoughts or made attempts?
_____ Yes _____ No

If so, what kinds and during what part of your life? _____

_____

_____

_____

_____

Have you ever experienced self harm, nutritional avoidance, or exercise or eating disorders?

If so, what kinds and during what part of your life? _____

_____

_____

_____

_____

Have you experienced a compulsion to harm others or had homicidal thoughts?

_____ Yes _____ No

If so, please explain: _____

_____

_____

Are you aware of any possible medical or genetic causes for ANY of the above issues you have listed?

_____ Yes _____ No

If so, please explain: _____

_____

_____

_____

_____

What are the most important things you hope to gain through this therapeutic process?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____