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Outpatient Counseling New Client Information

In order to serve you best, please fill out by hand (do not type) as completely as possible and bring to first session along with your insurance card and copayment or payment

Date _____ Name _____ Birth date_____ Age _____

Address _____
Street City State Zip

Email _____@_____

Phone _____/ _____/ _____
Home Cell Work

***** Please indicate any objection you have to a voicemail being left *****

Permission to use TEXT messaging for administrative tasks such as scheduling? Yes _____ No _____

Gender: *Male* *Female* Ethnic Origin _____ *Decline to Specify*

Marital status: *Single* *Married* *Living Together* *Separated* *Divorced* *Widowed*

Sexual Orientation: _____ Spouse/Partner's name _____

Annual Household income $_____ Current Occupation_____

Employer_____ Military History? _____

Highest level education completed: _____ Religious affiliation _____

Attend regularly? ☐ yes ☐ no Where_____

Previously therapy/counseling? Yes ___ No ___ When? _____

What type: Individual ___ Couples ___ Family ___ Group __

Issues addressed in therapy? _____ Was it helpful? ☐ yes ☐ no

How did you come to choose me as a provider? _____

Please describe the quantity and frequency of your use of the following:

Alcohol _____ Caffeine _____

Cigarettes/other tobacco products: _____

Marijuana _____

Other substances (legal or illegal) _____

_____

Primary Care Provider _____ Phone _____

Medical Conditions _____

_____

Medications _____

Family Information

Name	(circle one)	Age	Alcohol/Drugs	Mental Illness	Quality of Relationship
Mother	(Biological, Adoptive, Foster, Step)				
Father	(Biological, Adoptive, Foster, Step)				
Mother	(Biological, Adoptive, Foster, Step)				
Father	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				
Sibling	(Biological, Adoptive, Foster, Step)				

Where are you in the birth order? (oldest, 2nd daughter/son, youngest, etc.) _____

Have you experienced any trauma/abuse (rape, abortion, miscarriage, assault, domestic violence, physical or emotional abuse)? _____

_____

Who is living in your home? _____

Names and ages of your children: _____

You were raised by: *both parents* *single parent* *other (who?)* _____

Other family information you think would be helpful to know? _____

_____

_____

Recent Life Changes:	**Current Problem Areas:**	**Current Symptoms:**	
☐ Medication	☐ Relationships/Marriage/Friends	☐ Homicidal Thoughts	☐ Suicidal Thoughts
☐ Health	☐ Family/Parenting	☐ Repetitive Thoughts	☐ Panic
☐ Primary Care Provider	☐ Finances	☐ Flashbacks	☐ Worry
☐ Relationship Status	☐ Access to Medical Care	☐ Paranoia	☐ Anxiety
☐ Occupation/Education	☐ Transportation	☐ Concentration Difficulties	☐ Phobia
☐ Finances	☐ Stress: Work, Home	☐ Fatigue/Lethargy	☐ Guilt
☐ Housing	☐ Legal	☐ Sleep Problems	☐ Depression, Sad
☐ Legal	☐ Alcohol, Drugs, Gambling, Porn	☐ Appetite Problems	☐ Anger
	☐ Domestic Violence	☐ Binging/Purging/Not eating	☐ Self-Harm
	☐ Grief/Loss	☐ Drug/Alcohol Problems	☐ Numb
	☐ Anger Management	☐ Sexual Concerns	☐ Paralyzed/Frozen
	☐ Physical Pain/Problems	☐ Hallucinations/Delusions	☐ Negative Thoughts
			☐

How difficult have those problems made it for you to: do your work, take care of things at home, or get along with other people?

☐ **not difficult at all** ☐ **somewhat difficult** ☐ **very difficult** ☐ **extremely difficult** _

Please briefly describe your reason for wanting therapy at this time: _____

_____

_____

How long has this been an issue? _____

_____

What have you done to try to improve the situation or issue? _____

_____

_____

Is there any other information I didn't ask that you feel that I should know? _____

_____

_____

_____