# New Client Information Form

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Today's Date: ______________

**About You:**

Name:___________________________________ Date of Birth:________________________

Address:______________________________________________________________________

Cell Phone: _________________________ Work Telephone: __________________________

Occupation: _______________________________ Email: _____________________________

Present Marital Status: ☐Single ☐Living Together ☐Engaged ☐Married

☐Separated ☐Divorced ☐Widower ☐Remarried

**Your Spouse/Partner:**

Name:___________________________________ Date of Birth:________________________

Address:______________________________________________________________________

Cell Phone: _________________________ Work Telephone: __________________________

Occupation: _______________________________ Email: _____________________________

**Your Family:**

Name(s) of those living in your household _________________________________

_________________________________ _________________________________

**Emergency Contact (consent to contact in case of emergency):**

Name:_______________________ Relationship to Client(s): ___________________________

Home Telephone: ________________________ Cell: _________________________________

## Description of Presenting Issues:

What brings you to therapy at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for therapy?

Have you seen a mental health professional before? If so, please specify dates, the reason for therapy, and your experience. What was your diagnosis, if any?

## Medical History:

Primary Care Physician:___________________________ Telephone: ______________________

Please list medications you are currently taking:

Name & dosage: _________________________ Prescribed for: __________________________

Any side effects? _________________________ Helpful? ______________________________

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Name & dosage: ____________________________ Prescribed for: ______________________

Any side effects? ___________________________ Helpful? __________________________

Do you have any allergies?

Do you have any significant health concerns?

Describe any physical pain/issues which may be related to reasons you are seeking therapy:

**Mental Health History:**

Do you have difficulty falling asleep? ___________ How many hours do you average each night? _____

Do you have difficulty maintaining a healthy weight?

Do you drink alcohol? If yes, please describe the type, amount and frequency.

Do you use recreational drugs? If yes, please describe the type, amount and frequency.

Do you currently, or have you ever had suicidal thoughts? Please describe.

Have you ever attempted suicide?

Do you ever have thoughts or urges to harm others?

Have you ever been hospitalized for a psychiatric issue?

Is there a history of mental illness in your family? Please list.

Please check any of the following you have experienced in the past six 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
- Anxiety
- Panic
- Hopelessness
- Self-Harming Behaviors
- Suicidal Thoughts
- Homicidal Thoughts
- Physical Aggression Towards Others
- Hearing Voices That Others Do Not
- Seeing Things That Others Do Not
- Binging/Purging
- Restricted Eating

Is there anything else you would like me to know?

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