NEW CLIENT INFORMATION FORM

Please fill out the following form to the best of your ability. If you are not comfortable answering certain questions, we can discuss them in person.

Name ____________________ Birth date ____________________ Age __________

Address ____________________ City, State, Zip ____________________

Phone Number ____________________ Ok to leave message? Yes ☐ No ☐

Email ____________________ Ok to leave message? Yes ☐ No ☐

Preferred method of contact (for scheduling purposes only) Voicemail ☐ Text ☐ Email ☐

Emergency contact #1: Name ____________________ Relationship ____________________

Phone number(s) ____________________

Emergency contact #2: Name ____________________ Relationship ____________________

Phone number(s) ____________________

Gender Identity ____________________ Religious Preference ____________________

Sexual Orientation ____________________ Highest Level of Education __________

Ethnic/Cultural Background ____________________

Occupation ____________________ Employer ____________________

Referred by ____________________

What brings you to therapy?

____

____

What are your goals for therapy?

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____

Have you been in psychotherapy before? Yes ☐ No ☐

If yes, please indicate your therapists' names, when you saw them, how long you remained in treatment, and whether it helped: ____________________

____

____

Are you currently taking any psychiatric medications? Yes ☐ No ☐

If yes, please indicate which medications, dosage, and reason for taking: ____________________

____

____

Please list any previous psychiatric medications: ____

____

Have you ever been psychiatrically hospitalized? Yes ☐ No ☐

If yes, please indicate dates and reasons: ____

____

Do you have any history of eating disorder symptoms? Yes ☐ No ☐

If yes, please indicate symptoms: ____

Have you had any recent suicidal thoughts? Yes ☐ No ☐

If yes, please describe: ____

____

Have you ever attempted suicide? Yes ☐ No ☐

If yes, please indicate dates and methods: ____

____

Have you ever intentionally harmed yourself or others physically? Yes ☐ No ☐

If yes, please describe: ____

____

Have you ever been physically, sexually, or verbally abused? Yes ☐ No ☐

If yes, please describe: ____

Do you have access to any guns/firearms or other weapons? Yes ☐ No ☐

If yes, what types and where are they located? ____

Have you ever been arrested or had any legal problems,? Yes ☐ No ☐

Do you have any history of alcohol or substance abuse? Yes ☐ No ☐

If yes, please describe:____

Do you have any family history of psychiatric illness, alcohol or substance abuse Yes ☐ No ☐

If yes, please list their relationships to you and their diagnoses/drug(s) of choice:

____

____

____

Do you have any chronic medical conditions? Yes ☐ No ☐

If yes, please describe: ____

Is there anything else you feel might be important to tell me? ______________________________

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