



New Client Information

Referred By: _____

Today's Date: ____/____/____

I. Client Information

Name: _____ Social Security #: _____

Birth Date: _____ Age: _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax #: _____

Email Address: _____

Work Phone: _____ Guardian's Work Phone (for minor): _____

Email: _____

Would you like to be added to our newsletter list?: yes / no

Would you be interested in completing a survey about your therapy experience? yes/ no

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Please complete this section for others residing in the client's home:

Name	Birth Date	Age	Relationship to Client	Gender

II. Occupational/Educational Status

Client currently employed? Yes/No If yes, Full-Time/Part-Time Occupation: _____

Spouse currently employed? Yes/No If yes, Full-Time/Part-Time Occupation: _____

For minor: Father currently employed? Yes/No If yes, Full-Time/Part-Time Occupation: _____

For minor: Mother currently employed? Yes/No If yes, Full-Time/Part-Time Occupation: _____

If guardian/s not employed, please check any of the following: Retired Unemployed Disability Student

III. Client's Health Status

Current or chronic medical issues: _____

Primary Care Doctor: _____ Phone: _____

IV. Client's Medication History

Have you previously taken medications for emotional/substance abuse problems? YES___ NO ___

Name: _____ Name: _____ Name: _____
 Dose (mg): _____ Dose (mg): _____ Dose (mg): _____
 Frequency: _____ Frequency: _____ Frequency: _____
 Are you currently taking any medications for emotional/substance abuse problems? YES ___ NO ___
 Name: _____ Name: _____ Name: _____
 Dose (mg): _____ Dose (mg): _____ Dose (mg): _____
 Frequency: _____ Frequency: _____ Frequency: _____

Other medications: _____
 Prescribing Physician: _____ Phone: _____

V. Client's Mental Health History

Have you had prior mental health related services? YES ___ NO ___

	Therapist/Facility	Date	Duration	Outcome
Prior Therapy	1)	1)	1)	1)
	2)	2)	2)	2)
	3)	3)	3)	3)
Prior Hospitalization(s)	1)	1)	1)	1)
	2)	2)	2)	2)
	3)	3)	3)	3)

VI. Problem Category (please check all that apply):

Emotional Health Family issues Work-related Financial
 Substance use/abuse Eating disorder Children Legal
 Suicide Risk Abuse/Violence Health-related Marital/Relationship issues
 Parent-Child issues Other: _____

VII. Family history

Describe any family behavioral health issues or diagnosis.

VIII. Client Background information

The following information is optional but will help us to better serve you.

Ethnicity American Indian/Alaskan Native Caucasian/White Asian or Pacific Islander Bi-Racial African-American/Black Multi-Racial Hispanic/Latino/a _____	Highest Level of Education of primary Guardian No High school Associate's Degree Some High school Bachelor's Degree High School Diploma Master's Degree Technical School Doctoral Degree Degree in: _____
Marital Status of parent's Living Together/Not Married Separated Married Divorced Widowed	Sexual Orientation Heterosexual Transgendered Gay/Lesbian Not sure/questioning Bisexual
Religious/Spiritual Affiliation:	