NEW CLIENT QUESTIONNAIRE

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Welcome to my practice. Thank you for taking a few minutes to fill out this form. The information that you provide is confidential and will be helpful to have when we meet for the first time.

Today's Date: _____

Name:_____ Age:_____ Date of Birth:____/ ____/_____

Address:_____

Phone (Primary): _____ (Secondary):_____

Email Address: _____@_____

Ethnicity: _____ Where did you grow up? _____

Education: _____ Occupation: _____ SSN: _____

Emergency contact person (name, relationship, phone): _____

Other family members living with you? (name, relationship): _____

_____

Have you participated in therapy before? Y___ N___If yes, when? _____ Reason: _____

Are you currently seeing a psychiatrist or other mental health specialist? Y___ N___ (name/title)_____

Have you or a family member ever been hospitalized for mental or emotional illness? Y___ N___

If yes, please explain-dates, where, reason: _____

Substance abuse/addiction history? No___ Yes (please explain)_____

Legal history (arrests, prison, DWI, parking tickets?) _____

Are you on any medications? N____ Y____ If yes, what and why? _____

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How can I help? Please tell me what brings you here today? _____

_____

What are your two most important goals for therapy?

1: _____

2:_____

Common problem/symptom checklist. Fill in 0-none, 1-mild, 2-moderate, 3-severe.

	Marriage		Divorce/separation		Alcohol/drugs		Being single
	Pre-marital		Child custody		Other addictions		Sexual issues
	Disabled		Grief/loss		Past hurts		Work/career
	Depression		Anxiety		Co-dependency		Family
	School/learning		Fear		Intimacy		Children
	Money/budgeting		Anger control		Communication		Parents
	Aging/dependency		Loneliness		Self-esteem		In-laws
	Weight		Mood		Mood swings		Stress control

Family Information

Marital Status (check any that apply): Single ____ Dating____ Committed relationship ____Engaged ____

Married____ Separated ____ Divorced____ Widowed____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y____ N____

If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger control problems? Y____ N____

If yes, explain_____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y____ N____

If yes, describe_____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N____

If yes, describe_____

Who referred you to me?_____

Thank you for taking the time to fill out this information sheet. We will review it together during our first meeting.