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New Client Information Sheet

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Marital Status: _____ Social Security #: _____

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

May I send information to this address? ___Yes ___No

If no, please provide an address where information can be mailed:

_____

_____

Home Phone Number: _____ May I contact you at this number? Yes No

Cell Phone Number: _____ May I contact you at this number? Yes No

Work Phone Number: _____May I contact you at this number? Yes No

If there are any further restrictions when calling you, please list them here _____

_____

Emergency Contact:

Name_____ Relationship _____

Home Phone Number _____Work Phone Number _____

How did you hear about me? _____

If a specific person referred you, who was it? _____

Do I have permission to write a thank you note to the person that referred you? (circle one) yes no

Please briefly describe your presenting concern(s): _____
_____
_____

Medical History

Please explain any significant medical problems, symptoms, or illnesses:

_____
_____
_____
_____
_____

Current Medication (Please indicate dosage)

Please include over-the-counter medications and vitamins:

_____
_____
_____
_____
_____
_____

Past Medications (Please indicate dates and dosage):

_____
_____
_____
_____
_____

Psychiatric History:

Have you ever been in therapy before? ___Yes ___No

If yes, please indicate who, when, where and why:

_____
_____
_____
_____
_____

May I contact any of your previous providers? ___Yes ____No

If yes, please provide their contact information:

_____

_____

_____

Have you ever been hospitalized for a psychiatric reason? ____Yes ____No

If yes, please indicate who, when, where and why:

_____

_____

Family Information:

Please list all the people that live in your household and their relationship to you:

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Please list any family members who do not live in your house, but are important in your life:

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Where they live_____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Where they live _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Where they live _____

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered from the following?

____Depression (Please circle one)
Who? _____ Past/Present

_____Anxiety
Who? _____ Past/Present

_____ADHD
Who? _____ Past/Present

_____Bipolar Disorder
Who? _____ Past/Present

_____Schizophrenia
Who? _____ Past/Present

_____Drug/Alcohol Abuse
Who? _____ Past/Present

_____Legal Trouble
Who? _____ Past/Present

_____Domestic Violence
Who? _____ Past/Present

_____Suicide
Who? _____ Past/Present

_____Physical Abuse
Who? _____ Past/Present

_____Sexual Abuse
Who? _____ Past/Present

_____Psychiatric Hospitalization
Who? _____ Past/Present

_____Learning Disabilities
Who? _____ Past/Present

_____Military Involvement
Who? _____ Past/Present

_____Financial Distress
Who? _____ Past/Present

_____Other
Who/What? _____ Past/Present

_____ _____
Signature of Client Date