Family Perspectives, L.L.C.

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) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 3)
Prior Hospitalization(s)	1) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 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 primaryGuardian** 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:	