, L.L.C.

New Client Information

Referred By:________________________ **Today's Date:** _____/___/_____

I. Client Information

Name:___________________________ Birth Date:___________ Age: ___ Gender: _______________

Address:______________________________________ City:_________ State:_____ Zip: ____________

Name:___________________________ Birth Date:___________ Age: ___ Gender: _______________

Address:______________________________________ City:_________ State:_____ Zip: ____________

Home Phone:____________ Cell Phone:__________________ cell phone (other)_________________

Email:__________________________________ Email (other): ________________________________

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

Email:________________________________ email (other) ___________________________________

Is it OK to leave messages via: text: Yes___ No___ Voice mail: Yes___ No___ email: yes___ No___

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: Dose (mg): Frequency: | Name: Dose (mg): Frequency: | Name: Dose (mg): Frequency:

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 circle all that apply):

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

VII. Family history

Describe any family behavioral health issues or diagnosis.

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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:	