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NEW CLIENT INFORMATION

Name: ______________________ Date of Birth: ______________________

SSN: ______________________

Gender: ☐ Male ☐ Female ☐ Other - Specify ______________________

Contact Information:

Address: ______________________

City: ______________ State: ______________ ZIP:

		OK to Contact?
Home:	( ) ______________________	☐ Yes ☐ No
Cell:	( ) ______________________	☐ Yes ☐ No
Work:	( ) ______________________	☐ Yes ☐ No
Email:	______________________	☐ Yes ☐ No

Referral Source (*Please provide the name and phone number of the person or agency that referred you for psychotherapy*.)

Name: ______________________ Phone: (   ) ______________

May I notify the referral source that you have made an appointment? ☐ Yes ☐ No

Emergency Contact Information:

Name: ______________________

Address: ______________________

City: ______________ State: ______________ ZIP: ______________

Phone: (   ) ______________________

Relationship: ______________________

About You:

Ethnicity: ______________________ Religion: ______________________

Highest Level of Education Completed: ______________________

Relationship Status:
- ☐ Single, not dating
- ☐ Single and dating
- ☐ Married
- ☐ Divorced
- ☐ Committed Relationship
- ☐ Widowed
- ☐ Other ______________________

Employer : ______________________ Job Title ______________________

Primary Care Physician: ______________________ Phone: ( ) ______________________

Therapist: ______________________ Phone: ( ) ______________________

Psychiatrist: ______________________ Phone: ( ) ______________________

Current Medical Conditions or Illnesses?

____

____

Current Medication(s) and Dosage(s)?

____

____

Presenting Issues (Please describe the concerns that lead you to seek therapy)

____

____

Are you currently using any substance (alcohol or other drugs) in a manner, which concerns you or has concerned others who know you?

____

____

Do you or any member of the family in which you were raised have a history of substance abuse or dependence?

____

____

What are your goals in seeking mental health services?

____

____

Please rate and comment on the following factors regarding your current level of satisfaction or dissatisfaction on each of the following dimensions.

Work/Career	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Romantic	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Family	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Friends/social	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Exercise/ Fitness	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Sex	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Spirituality	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments
Life Goals	0 1 2 3 4 5 6 7 8 9 10 Extremely Dissatisfied Very Satisfied	Comments

Client Signature: ______________________________ Date: ______________

Therapist Signature: ______________________________ Date: ______________