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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: _____