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Licensed Mental Health Counselor

NEW CLIENT INFORMATION

Client Name : _____

Date of Birth: ___/___/_____ Age:_____Gender:_____

Marital Status (circle one): single married divorced/separated

Address: _____

City: _____ State: _____ Zip Code: _____

Cell/Mobile Phone: _____ Home Phone:_____

Email: _____

THE BEST WAY TO REACH ME IS (circle one): Cell/Mobile Home

IS IT OK TO LEAVE MESSAGES REGARDING APPOINTMENT TIMES, ETC? (circle one): YES NO

IS IT OK TO SEND TEXT MESSAGES TO YOUR CELL/MOBILE? (circle one): YES NO

IS IT OK TO SEND MAIL TO THE ABOVE ADDRESS? (circle one): YES NO

IS IT OK TO SEND EMAIL'S TO THE ABOVE EMAIL? (circle one): YES NO

Please write any specific requests or limitations in communicating with you: _____

_____

Employed By: _____ Occupation:_____

City: _____ Date Hired: _____

How were you referred to this office? (circle): Self-Referred Doctor Family Friend Ad Internet Other

Name of internet site/ad/facility/friend/other: _____

Emergency Contact Person: _____Phone:_____

PLEASE DO NOT WRITE BELOW THIS LINE

Payment Due: $ _____ Diagnosis: _____

ADULT SELF-REPORT FORM

CHIEF CONCERN:

Please describe the main difficulty that has brought you to seek treatment at this time: _____

_____

_____

YOUR MEDICAL CARE: (From whom or where do you get your medical care?)

Primary Care Doctor _____ Phone: _____

Fax: _____ Date of Last Visit: _____

Address: _____

Medical Problems:_____

_____

Current medications prescribed by this provider:_____

_____

May we contact your primary doctor so that we can coordinate your treatment? (circle one): YES NO

Psychiatrist: _____ Phone: _____

Fax: _____ Date of Last Visit: _____

Address: _____

Psychiatric Problems:_____

_____

Current medications prescribed by this provider: _____

_____

May we contact your psychiatrist so that we can coordinate your treatment? (circle one): YES NO

Have you received previous psychological care? (circle one): YES NO

If YES, please indicate which type of treatment (circle): INPATIENT OUTPATIENT BOTH

When: ______________________________ From Whom: ____

For What: _____________________________________

---- ----

When: ______________________________ From Whom: ____

For What: _____________________________________

---- ----

When: ______________________________ From Whom: ____

For What: _____________________________________

---- ----

When: ______________________________ From Whom: ____

For What: _____________________________________

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May we contact your previous providers(s) for continuity of care? (circle one): YES NO

RACE/ETHNICITY:

(circle all that apply): American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Pacific Islander White Other: ________

RELIGION/SPIRITUALITY:

What religion/spiritual practices do you abide by, if any? ____

If religious/spiritual, in what ways do you practice or observe your faith?___________________________

____

DEMOGRAPHICS:

What city and state were you born in? ____

If not from the area, how old were you when you moved here? _____

What brought you to this area?_____

EDUCATION:

Highest Degree Obtained: _____ Major: _____

From Where: _____ Year: _____

PRESENT RELATIONSHIPS:

Below, List All Individuals Currently Living With You:

NAME AGE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

How do you get along with your spouse/partner? _____

_____

How do you get along with your children? _____

_____

HOUSING:

Do you own the house you are living in? (circle one): YES NO

If YES, what year did you buy it? _____

If NO, do you (circle all that apply): Rent Live with family Live with friends

Other: _____

LEGAL:

Do you have any pending legal issues? (circle one): YES NO

If yes, please describe: _____

_____

_____

Have you had any legal issues that have been settled in the last 10 years? (circle one): YES NO

If yes, please describe:_____

_____

SUBSTANCE USE:

Do you currently consume alcohol? (circle one): YES NO

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

What kind of alcohol do you consume? (circle): BEER WINE LIQUOR Other _____

Do you have a history of problematic use of alcohol? (circle one): YES NO

Have family members or friends expressed concern about your drinking? (circle one): YES NO

Do you currently use non-prescribed drugs or street drugs? (circle one): YES NO

If yes, what kind of non-prescribed drugs or street drugs do you take? _____

_____

Do you have a history of problematic use of prescription drugs? (circle one): YES NO

Do you have a family history of alcohol or drug problems? (circle one): YES NO

If yes, please describe: _____

_____

Do you currently smoke cigarettes? (circle one): YES NO

If yes, how many do you smoke per day? _____ Per week? _____

INTERESTS/HOBBIES:

What do you like to do in your spare time? _____

_____

LIST OF SYMPTOMS: (Please check any of the following that have been bothering you lately):

___ANGER
___ANXIETY
___ALCOHOL USE/ABUSE
___APPETITE
___AGORAPHOBIA
___AMBITION
___ASTHMA
___ALLERGIES
___BLOOD SUGAR PROBLEMS
___CHILDREN
___CONFIDENCE
___COMPULSIVITY
___CONFLICT
___CONCERN OVER HEALTH
___CHEST PAINS OR TIGHTNESS
___COLD HANDS OR FEET
___CONCENTRATION
___CAREER CHOICES
___DEPRESSION
___DIVORCE
___DIFFICULTY STAYING ASLEEP
___DIARRHEA
___DIZZINESS
___DRUG USE/ABUSE
___DWELLING ON THE PAST
___DECISION-MAKING
___DRIVING PHOBIA
___EXCESSIVE WORRY
___ENERGY (HIGH or LOW)
___EDUCATION
___EXCESSIVE EXERCISE
___FAINTING
___FAMILY VIOLENCE
___FINANCES
___FRIENDS
___FETISHES
___FEAR OF BEING ALONE
___FEAR OF PUBLIC PLACES
___FEAR OF CROWDS
___FEELING BORED
___FEELING HOPELESS
___FEELING HELPLESS
___FEELING WORTHLESS
___FRUSTRATION
___FEELING "BURNT OUT"
___FACE OR JAW PAIN
___FREQUENT URINATION
___FEELING EMOTIONAL
___GUILT
___HEART RACING
___HEADACHES
___HOMICIDAL
___HIGH BLOOD PRESSURE
___INADEQUACY
___IMPOTENCE
___INDIGESTION
___INABILITY TO RELAX
___INSOMNIA
___KNOTS IN STOMACH
___LONELINESS
___LYING
___LEGAL MATTERS
___LACK OF SEX DRIVE
___LOSS OF INTERESTS
___MARRIAGE
___MEMORY
___MIGRAINES
___MOODINESS
___NIGHTMARES
___NEGATIVE THOUGHTS
___NAIL BITING or HAIR PULLING
___NUMBNESS
___NERVOUSNESS
___OVER-EATING
___OBSESSIVE THOUGHTS
___OVERWEIGHT
___PANIC ATTACKS
___PERFECTIONISM
___PAINFUL THOUGHTS
___PAIN (back, neck, shoulders)
___PREOCCUPIED WITH DETAILS
___PREGNANCY
___POOR APPETITE
___RELATIONSHIPS
___RESTLESSNESS
___SEXUAL PROBLEMS
___SHYNESS
___SEPARATION
___SLEEP
___SUICIDALITY
___SELF-HARM
___SELF-CONTROL
___SELF-ESTEEM
___SPACING OUT
___SEXUAL ORIENTATION
___SHORT-TEMPER
___SEXUAL ABUSE
___SADNESS
___SERIOUS ILLNESS
___SOCIAL ISOLATION
___STRESS
___SEIZURES
___SUSPICIOUSNESS
___STARVATION
___TEARFULLNESS
___UNDERWEIGHT
___UNHAPPINESS
___VOMITING

For the next section, please use the following scale when answering. Write the number next to each area in the space provided:

- "1" = No Effect
- "2" = Little Effect
- "3" = Some Effect
- "4" = Much Effect
- "5" = Significant Effect
- N/A = Not Applicable

Please indicate how the issue(s) for which you are seeking treatment are effecting the following areas of your life, using the scale noted above:

MARRIAGE/RELATIONSHIP:_____ EATING HABITS: _____

FAMILY: _____ SLEEPING HABITS: _____

MOOD: _____ SEXUAL FUNCTIONING: _____

FRIENDSHIPS: _____ ALCOHOL/ DRUG USE: _____

FINANCES: _____ ABILITY TO CONCENTRATE: _____

PHYSICAL HEALTH: _____ JOB/ SCHOOL PERFORMANCE: _____

ANXIETY LEVEL/NERVES: _____ ABILITY TO CONTROL ANGER: _____

OTHER: _____

What other information about yourself do you think would be important for us to know?

_____

_____

_____

_____

_____ _____

PRINT Patient Name Date

_____ _____

SIGNATURE of Patient Date