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New Adult Client Information

PERSONAL INFORMATION Today's Date: _____

First Name: _____ Nickname: _____ Last Name: _____

Primary Address: _____ City: _____ State: ____ Zip:_____

Age: _____ Date of Birth: ____/____/____ Gender: _____

Cell Phone: (_____) _____ May we leave a voicemail message: ❑ Yes ❑ No

Home Phone: (_____) _____ May we leave a voicemail message: ❑ Yes ❑ No

Work Phone: (_____) _____ May we leave a voicemail message: ❑ Yes ❑ No

Email: _____ May we email you: ❑ Yes ❑ No

Preferred Email for reminder of scheduled appointments (if different): _____
Note: Phone and/or email correspondence is not considered to be a confidential medium of communication for clinical discussions.

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Widowed ☐Other

Employer/School: _____ Occupation: _____

Highest Level of Education: _____

EMERGENCY CONTACT(S)

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

CURRENT MENTAL HEALTH CONCERNS

Reason for Visit- Current concerns bringing you to therapy? _____

_____

_____

_____

What are your goals from therapy? _____

_____

_____

Current Home Concerns

Check:	Please describe:
❑ Emotional	
❑ Relational	
❑ Behavioral	
❑ Other	

Current Work Concerns

Check:	Please describe:
❑ Emotional	
❑ Social	
❑ Behavioral	
❑ Performance	

Current Prescriptions	Dosage	Frequency	Prescribed for	Using since	Prescribed by
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	

OTC Medications and Supplements	Reason Used	Frequency

Please check all items below that apply to your current concerns.

X	Concern	X	Concern
	Abortion		Indecisive
	Academic concerns		Infertility
	Addiction concerns		Internet/video game addiction
	ADHD/ADD		Intimate relationship concerns
	Adjustment/life changes		Irritable
	Aggressive behavior		Isolation/social withdrawal
	Aging parents		Learning concerns
	Alcohol		Legal concerns
	Anger/frustration management		Low energy/fatigue
	Anxiety, fear, nervousness		Loneliness
	Appetite changes		Lying
	Argumentative		Manic behavior
	Blended family issues		Marital affairs
	Burnout		Medical or health concerns
	Career/job		Memory problems
	Children/parenting		Mood swings
	Chronic pain		Motivation
	Codependency		Nail-biting
	Communication		Nightmares/night terrors
	Compulsive behavior		Obsessive thoughts
	Concentration difficulties		Overspending
	Crying		Paranoia
	Cutting or self-injury		Phobias
	Delusion/hallucinations		Physical abuse or assault (past or present)
	Depression/sadness		Picking
	Difficulty trusting others		Poor boundaries
	Distraction		Pornography
	Divorce/separation		Procrastination
	Domestic violence concerns		Relationship stress/conflict
	Drug use		Running away
	Eating concerns (binge, purge, obesity)		Self-control
	Eating Disorders (anorexia, bulimia, binging)		Self-esteem
	Emotional or psychological abuse (past or present)		Self-harming thoughts/actions
	Family concerns		Separation anxiety
	Fears of abandonment/rejection		Separation/marital concerns
	Feeling that you/things around you are not real		Sexual function
	Fidgeting		Sexual abuse or assault (past or present)
	Financial concerns		Sexuality concerns
	Fire setting		School/Work absenteeism/avoidance
	Flashbacks (not drug related)		Shyness
	Focusing difficulties		Single parent
	Forgetfulness		Sleep difficulties/changes
	Gambling		Social concerns/social skills struggles
	Grief/loss		Spiritual or religious concerns
	Guilt/shame		Stealing
	Harassment		Stress or tension
	Harming Animals		Suicidal thoughts/actions
	Hoarding		Thoughts racing/can't hold on to an idea
	Homicidal thoughts		Tobacco use
	Hopelessness		Transition difficulties
	Hormone struggles/PMS		Trouble making decisions
	Hygiene/self-care		Unemployment
	Hyperactive		Violence
	Impulse control		Weight loss/gain +/- _____lbs
	Inappropriate sexual behavior		

PAST MENTAL HEALTH

Past mental health or substance use issues:

_____

_____

Any previous therapy? ❑ Yes ❑ No If yes, with whom? Dates? ___ _____

Reason? _____

Helpful? ❑ Yes ❑ No ❑ Some Comments: _____

Reason for discontinuing therapy: _____

Previous diagnoses? ❑ Yes ❑ No If yes, please explain: what diagnosis, age, name of doctor. _____

_____

_____

Past Psychological/learning evaluation or testing? ❑ Yes ❑ No If yes, name of clinician and date: _____

_____

Past suicidal thoughts or attempts? ❑ Yes ❑ No If yes, when: _____

Past homicidal thoughts or attempts? ❑ Yes ❑ No If yes, when: _____

Past traumatic experience(s)? ❑ Yes ❑ No If yes, please list when and briefly describe: _____

_____

Previous in-patient psychiatric hospitalization? ❑ Yes ❑ No If yes, number of hospitalizations: _____

Please list date of and reason for hospitalization(s). _____

_____

Family History of Psychiatric/Emotional/Behavioral/Substance Abuse problems: _____

_____

_____

List any significant mental or substance abuse problems that you have previously experienced: _____

_____

_____

Drug Use	None	Past	Current		None	Past	Current
Alcohol	☐	☐	☐	Cocaine	☐	☐	☐
Marijuana	☐	☐	☐	Heroin	☐	☐	☐
Stimulants	☐	☐	☐	Steroids	☐	☐	☐
Hallucinogens	☐	☐	☐	Other	☐	☐	☐ _____

Drug of choice: _____ Quit on: _____

Caffeine: ❑ No ❑ Yes Amount/Day: _____ Source: _____

MEDICAL HISTORY

Primary Physician: _____ Phone: _____ Date of Last Exam: _____

Psychiatrist: _____ Phone: _____ Date of Last Session: _____

Height: _____ Weight: _____ Recent Weight Gain/Loss: _____

Exercise: ❑ No ❑ Daily ❑ Weekly: _____times/week Pregnancies: _____ Number of children: _____

Do you have any physical disabilities/limitations? ❑ Yes ❑ No If yes, please explain: _____

_____

Prior Hospitalizations/Surgeries/Injuries

Year	Hospitalizations/Surgeries/Injuries	Complications or Other Comments

List any significant medical problems that you have previously experienced or are currently experiencing: _____

_____

_____

Spiritual/Religious? ❑ Yes ❑ No If yes, briefly describe: _____

Strengths, Hobbies & Interests: _____

_____

_____

Community Involvement (groups, clubs, etc.):_____

_____

_____

Please describe your support system. Who are those closest to you? (family, friends, etc.) _____

_____

_____

Any other important information that you want to share: _____

_____

By signing below, I certify all information is true and correct to the best of my knowledge.

_____

Client Name (Please Print)

_____ _____

Client Signature (If dependent/ward, legal guardian signature) Date