THE TRAUMA ACADEMY NORTHWEST LLC
Training & Consultation for Organizations

New Client Paperwork

Name:

First	Last

Address:

street address

street address #2

city	state	postal code

Email Address (optional):	Phone number:	Texting:
		Yes No

home or cell

Date of Birth:	Sex:	Marital Status:
	Male Female Transgender	Single Married Divorced Widowed

circle one circle one

Emergency contact:

first	last

relationship	contact number

Insurance (write N/A if none):	ID number:	Group number:

Occupation:	Employer

Briefly describe why you want to begin therapy with us:

_____

_____

_____

What goals do you have for your time in therapy with us?:

_____

_____

_____

Others in Household**:**

Name:	Age:	Relationship to you:

Educational History:

Currently in school:	yes no
Highest grade competed:	

Medical History and Information:

	Directions/guidance:	Responses in this column:
Describe your health:	excellent good fair poor	
Physician Name:	write N/A if none currently	Phone number:
Last appointment:		
Current medication:	Dose:	Used for:

Activities of Daily Living:

Sleeping habits?	excellent good fair poor
Current sleeping problems and length of time (write N/A if none):	
Current eating problems and length of time (write N/A if none):	
Current hygiene problems and length of time (write N/A if none):	
Allergies:	

Military History:

Served in armed forces?:	yes no
If so, when?:	
Branch:	

History of Drug or Alcohol Use:

Current drug or alcohol use?	Never	"Experimented"	A couple times/month	Weekly
Treated for drug/alcohol problem?	Never	Once	More than once	
Currently in a recovery program?	Yes			No
Family history of D/A use?	Yes			No
Has anyone expressed concerns for your drug/alcohol use?			Yes	No

If "yes" to last question, please describe below:

_____

_____

_____

_____

Therapeutic History:

Briefly state your prior experience with counseling, psychiatric hospitalization, drug or alcohol treatment:

_____

_____

_____

_____

_____

Legal History:

Are you currently involved in the legal system?	yes	no

If yes, please describe:

_____

_____

_____

Trauma History:

Please mark traumas that you have experienced at least one time, during which you felt out of control or felt a loss of power.

	Relocated/Moved		Physical abused		Emotional abused
	Parental divorce		Neglected		Sexually abused
	Homeless		One parent household		Went with little/no food
	Feel taken advantage of		Stolen from		Family incarceration
	Low/no income		Witness domestic violence		Own divorce
	Personal DV history		Legal involvement		Single parent
	Community violence		Natural Disaster		Other

Please comment on any identified traumas to better help us understand your experience:

_____

_____

_____

_____

_____

Current Physical and Emotional Symptoms:

Please rate the importance of the following concerns using the following scale. If the area is not a problem for you, please leave it blank.

Mild = 1 Moderate = 2 Serious = 3 Severe = 4 Extreme = 5

	Job		Loss of appetite		Relationship problems
	Financial problems		Weight concerns		Legal problems
	Health problems		Difficulty sleeping		Problems at school/work
	Other family problems		Quick mood changes		Restless/can't sit still
	Sadness/Depression		Hard to make/keep friends		Feeling lonely
	Alcohol/Drugs		Isolating		Feeling worthless
	Sexual problems		Loss of interest in activities		Dwelling on Problems
	Suicidal/Homicidal		Pessimistic about future		Loss of energy
	Untrustworthy		Coping with divorce		More energy than usual
	Nervous/tense		Controlling thoughts		Panicky
	Guilt ridden		Frustrated/angry		Nightmares
	Hear/see things		Cry without clear reason		Spirituality
	Feel used by others		Marital problems		Fears/worries

	Chronic pain		Sweating		Hot/Cold spells
	Upset stomach		Twitching		Dizziness
	Health problems		Numbness/tingling		Headaches
	Stomachaches		Nauseous/Vomiting		Double vision
	Memory problems		Confused		Difficulty concentrating
	Common racing heart		Difficulty breathing		Other

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider some of your weaknesses?

_____

_____

_____