

## New Client Paperwork

Name:

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First

Last

Address:

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street address

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street address #2

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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:

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first

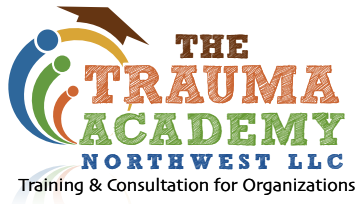
last

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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:

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

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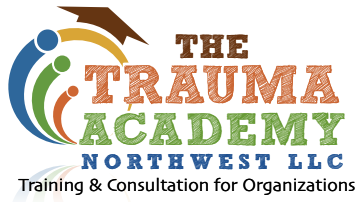
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Others in Household:

Name:	Age:	Relationship to you:

Educational History:

Currently in school:	yes	no
Highest grade completed:		

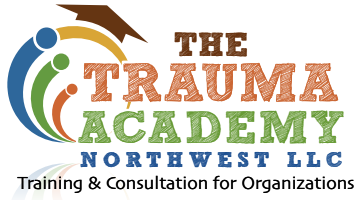


Medical History and Information:

	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:

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Therapeutic History:

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

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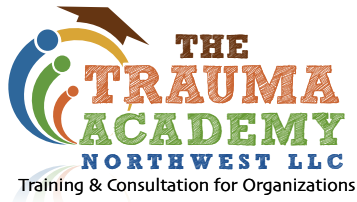
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Legal History:

Are you currently involved in the legal system?	yes	no
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If yes, please describe:

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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.

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

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

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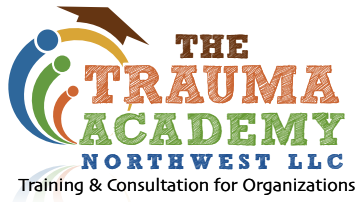
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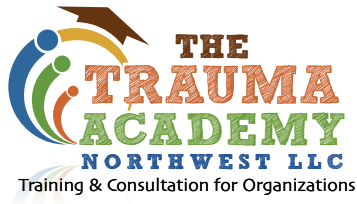
**Current Physical and Emotional Symptoms:**

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?

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What do you consider some of your weaknesses?

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